Supreme Court, U.S.
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No. 071102

In The
Supreme Court of the United States

CHARLES AND LESA CANAS, as Natural Guardians and Next Friends of DEREK CANAS, and DEREK CANAS, Individually,

Petitioners,

v.

AYMAN AL-JABI, M.D.; SHARON J. KAMINER, M.D.; BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA d/b/a MEDICAL COLLEGE OF GEORGIA HOSPITALS AND CLINICS; and MCG HEALTH, INC.,

Respondents.

On Petition For Writ Of Certiorari To The Supreme Court Of Georgia

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether Georgia's medical malpractice statutes of limitations/repose which mandate that a child must file a medical malpractice lawsuit prior to the age of majority denies the child equal protection and due process of law under the Fourteenth Amendment when Georgia law (a) otherwise recognizes that a child is incapable of protecting his or her own rights; (b) provides that a child lacks the capacity to sue in his or her own behalf; and (c) tolls the child's claims until the age of majority, except in medical malpractice cases?

2. Whether the Supreme Court of Georgia's holding that the same statutes of limitations/repose run from the date of the first failure to diagnose an injury, thereby barring any claim for later negligent acts and resultant injuries, is so arbitrary and capricious, or renders the laws so vague and indefinite, as to deny Derek Canas, a minor patient, due process of law?

3. Whether the same statutes deny Canas and others similarly situated and injured by medical malpractice due process and equal protection because Georgia courts construe these statutes to bar some, but not all, claims resulting from latent medical negligence or injuries, where those claims are not discovered within the prescribed time periods?

QUESTIONS PRESENTED – Continued

4. Whether Georgia's rejection of constitutional challenges to these statutes is flawed when multiple state and federal courts have reached contrary results by employing the same "rational basis" analysis as Georgia or, alternatively, by applying "heightened intermediate scrutiny"?

LIST OF PARTIES

The parties are as shown in the caption of the case. The Board of Regents of the University System of Georgia includes the following: Kenneth R. Bernard, Jr.; James A. Bishop; Hugh A. Carter, Jr.; William H. Cleveland; Robert F. Hatcher; Felton Jenkins; James R. Jolly; Donald M. Leebern, Jr.; Elridge McMillan; Patrick S. Pittard; Doreen Stiles Poitevint; Willis J. Potts; Wanda Yancey Rodwell; J. Timothy Shelnut; Benjamin J. Tarbutton, III; Richard L. Tucker; and Allan Vigil.

RULE 29.6 DISCLOSURE STATEMENT

MCG Health, Inc. is a non-profit 501(c)(3) corporation. It does not issue stock and has no shareholders.

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OPINION BELOW

Petitioners seek a writ of certiorari from this Court raising due process and equal protection challenges to O.C.G.A. §§ 9-3-71 and 9-3-73 (statutes of limitations/repose) under the Fourteenth Amendment. They petition from the judgment of the Supreme Court of Georgia in *Kaminer v. Canas*, 653 S.E.2d 691 (Ga. 2007) (Appendix A) which in a 4-3 decision reversed in part the opinion of the Georgia Court of Appeals, *Canas v. Al-Jabi*, 639 S.E.2d 494 (Ga. App. 2006) (Appendix B), and held that petitioners claims against the respondent doctors were time barred altogether. Petitioners'[1] complaint was brought in 2001 within nine months of discovery by another doctor that Derek Canas had AIDS, which resulted from one or more HIV contaminated blood transfusions received during infant heart surgery at the Medical College of Georgia ("MCG") in 1985. Kaminer treated Canas at MCG over a period of ten years and Al-Jabi for an eight-year period. Petitioners argued their claims were unconstitutionally truncated by the trial court, which granted respondents partial summary judgment, and limited petitioners' claims to negligent acts occurring within five years of the lawsuit and injuries arising within two years of filing, even though it found the application of the statutes "absurd."

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[1] Derek Canas became *sui juris* on November 1, 2002 during the litigation and then by stipulation continued the case in his own name.

After the Supreme Court of Georgia first declined review of petitioners' due process and equal protection challenges (Appendix C),[2] petitioners filed a motion for reconsideration which was denied (Appendix F). The case was then transferred to a Georgia Court of Appeals panel, which unanimously affirmed the trial court ruling as to the application of the statutes, surveying Georgia law interpreting them. It re-affirmed the constitutionality of the challenged statutes. *Id.* at 507, 511.

That court reasoned that evidence of new and different manifestations of the AIDS condition could trigger a new and different failure to diagnose, such that petitioners could assert claims for negligent acts which occurred within five years of the filing of the lawsuit. *Id.* at 510. It further found that any injury from a new negligent act could not have occurred before the act; thus any injuries sustained within two years of a later misdiagnosis were not time barred. *Id.* at 515.

Petitioners again unsuccessfully sought review on the same constitutional grounds, and respondents also sought certiorari. The Supreme Court of Georgia granted certiorari to hear only the claims of the respondent doctors that the case against them was not time limited by the statutes, but time barred altogether.

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[2] That Order resulted in the first petition (No. 05-1671) to this Court, denied October 2, 2006.

The court then held the limitations statute ran from the date each doctor *"first"* misdiagnosed the child's AIDS condition, thereby time barring all claims for later negligent acts and injuries. 653 S.E.2d at 695. It misapprehended that AIDS was not the injury caused by the negligent acts, but rather the myriad illnesses which followed from failure to diagnose.[3] All claims against either doctor were barred because each *first* failed to diagnose the AIDS condition more than five years prior to the complaint, and had thereby "injured" Canas more that two years prior to its filing. The statutes ran without notice to petitioners of the AIDS condition, without notice that

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[3] The Human Immunodeficiency Virus (HIV) is transmitted by direct blood-to-blood contact or by sexual contact with an infected individual. Once a person becomes infected with HIV, the virus attaches itself to T4 cells which are responsible for immune function in humans. The virus then multiplies and impairs the immune system, ultimately allowing other infections to occur far more frequently than normal, with devastating effects. Once a person has been infected with HIV, the virus begins to incubate over time. Thus, although a person infected with the virus may remain asymptomatic and may appear well in all respects, the virus continues to affect the host's immune system until it becomes so depressed that a limitless number of life-threatening infirmities may occur. The period in which the virus incubates is indeterminate. It may be as short as one year and can extend as long as fourteen years. Because of its inherent latency, HIV will likely be undetected for a long period of time. Thus, in cases such as this, where HIV has been transmitted through a blood transfusion, the discovery rule is particularly applicable since the prospective plaintiff will have no indication that he carries the virus. *Murray v. Hamot Medical Center*, 633 A.2d 196, 200 (Pa. 1993). (Internal citations omitted.)

either doctor was negligent, and without notice that later illnesses resulted from, or were exacerbated by, the numerous failures to diagnose AIDS.

Petitioners yet again sought reconsideration on the same due process and equal protection grounds. The court denied petitioners' motion without further comment on these arguments. Foreclosed with finality from asserting any claim against either doctor, petitioners seek certiorari to review their Fourteenth Amendment challenges to the statutes. The first petition to this Court sought review of the one page Order refusing to hear the constitutional challenges to the statutes first held to *truncate* petitioners' claims; this petition now challenges them based on the arbitrary elimination of *all* claims against respondent doctors in *Kaminer*. 653 S.E.2d 691.

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. § 1257(a). The Order and Opinion of the Supreme Court of Georgia dated October 29, 2007, is a final decree as contemplated under 28 U.S.C. § 1257(a) because the Order foreclosed further consideration of the Fourteenth Amendment challenge to the statutes in question and ended all claims against the doctors. *See Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469 (1975). The timely filed motion for reconsideration was denied on December 14, 2007 (Appendix G). Respondent Board of Regents has been represented

throughout the proceedings by the Attorney General of Georgia who has the requisite notice of petitioners' constitutional challenges to the statutes.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

U.S. Const., amend. XIV, § 1:

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

O.C.G.A. § 9-3-71. General limitation.

(a) Except as otherwise provided in this article, an action for medical malpractice shall be brought within two years after the date on which an injury or death arising from a negligent or wrongful act or omission occurred.

(b) Notwithstanding subsection (a) of this Code section, in no event may an action for medical malpractice be brought more than five years after the date on which the

negligent or wrongful act or omission occurred.

(c) Subsection (a) of this Code section is intended to create a two-year statute of limitations. Subsection (b) of this Code section is intended to create a five-year statute of ultimate repose and abrogation.

(d) Nothing contained in subsection (a) or (b) of this Code section shall be construed to repeal Code Section 9-3-73, which shall be deemed to apply either to the applicable statutes of limitation or repose. [1985 statute currently in effect.]

O.C.G.A. § 9-3-71. General limitations.[4]

Except as otherwise provided in this article, an action for medical malpractice shall be brought within two years after the date on which the negligent or wrongful act or omission occurred. [Invalid 1976 version of statute.]

O.C.G.A. § 9-3-72. Foreign objects left in body.

The limitations of Code Section 9-3-71 shall not apply where a foreign object has

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[4] This former version of O.C.G.A. § 9-3-71 was enacted in 1976, and was held unconstitutional in *Shessel v. Stroup*, 316 S.E.2d 155 (Ga. 1984) after being held unconstitutional in its application to a wrongful death case where the death occurred more than two years after the negligent act in *Clark v. Singer*, 298 S.E.2d 484 (Ga. 1983).

> been left in a patient's body, but in such a case an action shall be brought within one year after the negligent or wrongful act of omission is discovered. For the purpose of this Code section, the term "foreign object" shall not include a chemical compound, fixation device, or prosthetic aid or device.

O.C.G.A. § 9-3-73. Certain disabilities and exceptions applicable.

(*See,* Appendix H).

STATEMENT OF THE CASE

Derek Canas, born November 1, 1984, contracted HIV from a contaminated blood transfusion during infant heart surgery at the Medical College of Georgia ("MCG") hospital in the first quarter of 1985, shortly before the FDA implemented a blood screening test for HIV. Derek was continuously monitored by the pediatric cardiology department at MCG, the last ten years by respondent Kaminer.[5] She was an employee of the respondent Board of Regents, which operated the hospital during her tenure. Respondent Al-Jabi treated Derek from 1993 through March 15, 2000, on more than 39 visits.

[5] Kaminer saw Derek on 16 occasions from May 17, 1991 through February 15, 2001. He was asymptomatic on several of those visits.

On each occasion that he was seen by Al-Jabi for different illnesses, including pneumonia, tooth decay requiring surgery, stunted growth, bronchitis, irritable bowel syndrome and diarrhea, Derek had undiagnosed HIV/AIDS. Because AIDS portends a continuing deterioration of the auto-immune system, if undiagnosed and untreated it gives rise to myriad other injuries and illnesses. The stunted growth resulted from AIDS, although the family was told repeatedly by the respondents that it was a by-product of the congenital heart condition. Eventually, in 2000 another doctor referred Derek to a University of Florida hospital where, after several months of investigation, the correct diagnosis was made in April 2001.

The complaint was filed against the doctors on December 28, 2001, within nine months of the AIDS diagnosis, and within two years of Derek's last treatment by either doctor. It alleged recurring acts of negligence from 1994 forward, resulting in myriad diseases. All respondents were sued within five years of some, but not all, negligent acts.

Respondents moved for summary judgment based on the medical malpractice statutes of limitations/repose. Petitioners argued that they were unconstitutional, facially, or if applied to truncate or time bar their claims. The trial court granted partial summary judgment to respondents under O.C.G.A. § 9-3-71, barring petitioners' claims for wrongful acts which occurred more than five years before the complaint and for those injuries which occurred more than two years before its filing (Appendix D). In a separate

order, the trial court affirmed the constitutionality of O.C.G.A. §§ 9-3-71 and 9-3-73, rejecting equal protection and due process challenges (Appendix E).

The Supreme Court of Georgia then declined petitioners' appeal, holding *sua sponte* that the constitutional challenges to O.C.G.A. §§ 9-3-71 and 9-3-73 had already been decided adversely in prior decisions (Appendix C). In their motion for reconsideration, petitioners urged that (1) in prior review of these statutes, while articulating a "substantial relation" test, the court nonetheless incorrectly applied a rational basis test in affirming their constitutionality under the Fourteenth Amendment and the Georgia Constitution; (2) other state and federal courts had invalidated indistinguishable statutes under either rational basis or heightened intermediate scrutiny analysis; and (3) the statutes could not be constitutionally conformed to other Georgia statutes which protect the rights of minors, toll their claims until majority, and acknowledge that minors are incapable of protecting themselves.[6] Petitioners

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[6] O.C.G.A. § 1-2-8 provides that minors are incapable of protecting their rights. Infants must sue through a guardian or next friend, and the law recognizes that a parent or nearest relation may neglect to protect the infant's rights. *See, Sanders v. Hinton*, 156 S.E. 812, 815 (Ga. 1931). A minor's suit not brought through a guardian or next friend is an amendable defect in the record. O.C.G.A. § 9-2-28. Claims of minors are tolled until the age of majority. O.C.G.A. § 9-3-90 (except in medical malpractice cases). The age of majority in Georgia is eighteen. O.C.G.A. § 39-1-1.

argued that all claims should be tolled until Derek's eighteenth birthday or, alternatively, until discovery of AIDS. A contrary construction was unconstitutional.

After the motion was denied, the Georgia Court of Appeals. 639 S.E.2d 494 (Ga. App. 2006) reviewed the trial court orders. It affirmed, holding that evidence of new and different illness manifestations from the AIDS condition could trigger a new and different negligent act in failing to diagnose it, such that Canas could assert claims which occurred within five years of those acts. *Id.* at 510. It found that injury from a new negligent act could not have occurred before the act; thus injuries sustained within two years of a later misdiagnosis were not time barred. *Id.* at 515. It rejected petitioners' equal protection and due process challenges. It applied the minors' tolling statute only to claims against the hospital, not grounded in medical malpractice. *Id.* at 518.

The Supreme Court of Georgia then agreed to review only the doctors' assertion that the statutes barred all claims. It reversed, holding in a 4-3 decision that the "new injury" common law exception to the limitations statute did not apply, and that the limitations period ran from the date each doctor first failed to make the correct diagnosis. 653 S.E.2d 691. The holding ignored the plain language of the repose statute, which runs from the date of "a" negligent act, and the limitations statute which runs from the date of "an" injury. The court ignored those appellate

decisions interpreting the limitations period as tolled by a discovery or manifestation of injury rule.[7] It eschewed the "new injury" exception to the limitations statute which applies "only 'in the most extreme circumstances . . . '" *Id.* at 697. Later negligent acts or the child's later illnesses were immaterial because the child's "injuries" were not diseases which resulted from AIDS, but HIV/AIDS itself. The dissent criticized the majority's "single, indivisible injury" determination and its application of the statutes, demonstrating the arbitrary manner in which they applied. 653 S.E.2d at 698. Petitioners' continuing constitutional arguments were ignored in the opinion and in its timely motion for reconsideration.

REASONS FOR GRANTING THE WRIT

Medical malpractice statutes of limitations and repose in some states override tolling statutes which recognize that minors are incompetent or unable to vindicate their rights. The statutory scheme at issue is widely replicated and the constitutional analysis of

[7] *See, e.g., Whitaker v. Zirkle*, 374 S.E.2d 106 (Ga. App. 1988) (*cert. denied*) (statute does not run on misdiagnosis of cancer injury until cancer metastasizes); *Jones v. Lamon*, 426 S.E.2d 657 (Ga. App. 1992) (injury occurs when physically manifest to patient); *Vitner v. Miller*, 430 S.E.2d 671 (Ga. App. 1993) (*cert. dismissed*) (statute runs when symptoms manifest to patient) and *Stafford-Fox v. Jenkins*, 639 S.E.2d 610, 619 and n.12 (Ga. App. 2006) (listing 20 or more cases importing a discovery or manifestation rule to these statutes).

it among states is uneven and conflicted. O.C.G.A. § 9-3-71 produces arbitrary results because the repose period is triggered by a "negligent act," not routinely known to the patient and a limitations period triggered by an "injury," also often unknown to the patient. The Court should grant the writ because such statutes abridge the rights of children and patients, creating arbitrary classifications of them in medical cases, and divergent opinions as to whether patients or children are entitled to heightened Fourteenth Amendment protection. Their status under it remains unclear; they need its protection no less than women and minorities.

O.C.G.A. § 9-3-73 divested children of the protection of the minority tolling statute.[8] The challenged statutes force infants to sue for medical injuries by their seventh birthday when most are unable to communicate effectively and none have the legal capacity to sue. A further barrier to a child's right of action is O.C.G.A. § 9-11-9.1, which requires an affidavit from another doctor confirming a negligent act for a claim even to be actionable. Georgia then occasionally applies a discovery rule in select cases, and a "new injury" exception to the limitations period.

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[8] O.C.G.A. § 9-3-90 acknowledges that minors are not competent to assert their claims and tolls them until age of majority.

Other courts have determined that similar statutes deny equal protection or due process under the Fourteenth Amendment or like provisions in state constitutions.[9] The irreconcilable constitutional results sometimes depend upon whether the statutes receive "heightened intermediate scrutiny" or "rational basis" analysis. Texas, Arizona, Utah, Ohio, Colorado, New Hampshire, and New Mexico, among other states, repudiate Georgia's constitutional position with respect to conceptually identical statutes.[10] This Court should resolve the conflict; otherwise, this statutory scheme which fails Fourteenth Amendment analysis elsewhere, paradoxically comports with equal protection and due process in Georgia. Beyond multi-state conflicts, Georgia decisions construing these statutes are arbitrary, capricious and

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[9] *See, e.g., Austin v. Litvak,* 682 P.2d 41 (Colo. 1984), invalidating both statute of repose and limit of discovery rule to foreign object cases under state rational basis equal protection analysis tracking federal analysis: "[I]n both 'foreign object' and 'negligent misdiagnosis' cases the injured persons are wholly innocent and may, through no fault of their own, fail to discover their injury prior to the running of the statute of limitations." *Id.* at 52-53.

[10] *See, Sax v. Votteler,* 648 S.W.2d 661, 666-67 (Tex. 1983); *Kenyon v. Hammer,* 688 P.2d 961, 976 (Ariz. 1984); *Lee v. Gaufin,* 867 P.2d 572 (Utah 1993); *Austin v. Litvak,* 682 P.2d 41 (Colo. 1984); *Schwan v. Riverside Methodist Hosp.,* 452 N.E.2d 1337 (Ohio 1983) and *Mominee v. Scherbarth,* 503 N.E.2d 717 (Ohio 1986); *Carson v. Maurer,* 424 A2d 825 (N.H. 1980); *Jaramillo v. Eaton,* 100 P.3d 204 (N.M. Ct. App. 2004) *cert. denied,* 101 P.3d 807 (N.M. 2004); *Lyons v. Lederle Laboratories,* 440 N.W. 2d 769 (S.D. 1989).

replete with indecipherable exceptions. Concepts such as the continuing tort rule[11] and the discovery rule,[12] embedded in Georgia common tort law, are inexplicably abandoned in most medical cases. The Court should also grant the writ because the Supreme Court of Georgia's constitutional analysis of the statutes is superficial and wrong.

O.C.G.A. § 9-3-73 overrode the statute tolling minors' claims and survived a Fourteenth Amendment equal protection and due process challenge in *Smith v. Cobb County-Kennestone Hospital Authority,* 423 S.E.2d 235 (Ga. 1992). O.C.G.A. § 9-3-71 survived an equal protection challenge in *Craven v. Lowndes County Hosp. Auth.,* 437 S.E.2d 308 (Ga. 1993). Both statutes survived a further Fourteenth Amendment challenge in *Crowe v. Humana,* 439 S.E.2d 654 (1994). These decisions employed "rational basis" analysis.

In *Craven, supra,* three of the seven justices dissented and would have invalidated O.C.G.A. § 9-3-71(b) under a heightened "intermediate scrutiny" test, concluding that the right to sue for personal injuries is "an important substantive right," and urging the analysis employed in New Hampshire, which invalidated indistinguishable statutes in

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[11] *Everhart v. Rich's,* 194 S.E.2d 425 (Ga. 1972).

[12] *See, Luem v. Johnson,* 574 S.E.2d 835, 837 (Ga. App. 2002), citing *Lumberman's Mutual Cas. Co. v. Patillo Construction Co.,* 330 S.E.2d 334 (Ga. 1985).

Carson v. Maurer, 424 A.2d 825 (N.H. 1980).[13] The dissent advocated heightened scrutiny because the law restricted patients' rights to sue when compared to the rights accorded other personal injury claimants.[14]

Georgia decisions upholding the constitutionality of the statutes cannot be reconciled with *Shessel v. Stroup*, 316 S.E.2d 155 (Ga. 1984), which invalidated the earlier 1976 version of O.C.G.A. § 9-3-71 on equal protection grounds. Exactly like the current five-year period of repose embodied in the new version of the same code section, the earlier law (labeled a "limitations" statute) barred medical malpractice claims filed more than two years after a "negligent act." *Shessel* determined that the former statute denied equal protection because some medical claims did not give rise to a manifest injury until more than two years after the antecedent act. Thus, the 1985 version of the law, by calling the "negligent act" provision a statute of repose, and changing the time period from two to five years, transformed an irrational law into a rational one.

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[13] *Carson* also invalidated a special discovery statute for surgery/foreign object cases mirroring O.C.G.A. § 9-3-72. New Hampshire has since abandoned the *Carson* analysis and refashioned its intermediate scrutiny test to conform to the federal test. *See, Community Resources for Justice, Inc. v. City of Manchester*, 917 A.2d 707, 717 (N.H. 2007).

[14] *See also, Cantrell v. Thurmond*, 499 S.E.2d 416, 421 (Ga. App. 1998) holding the right to medical care is a "fundamental right."

The current statutes conflict with other Georgia limitation laws because only in medical cases does a period of repose begin to run from the date of an undiscovered negligent act. *See*, *Simmons v. Sonyika*, 614 S.E.2d 27 (Ga. 2005). The general statute of limitation for injuries to the person is two years from when the "right of action accrues" under O.C.G.A. § 9-3-33 upon which is a judicially engrafted discovery rule.[15]

Even if rules differentiating periods of limitation or repose in medical cases from other tort cases is constitutionally permissible, the statutes challenged here are (a) arbitrary and capricious as construed by the Georgia appellate courts in a body of conflicting decisions and (b) should be void for vagueness because they run upon discovery in some cases, but not others. Moreover, O.C.G.A. § 9-3-73 arbitrarily invests infants with the ability to protect their rights in medical cases, when Georgia law otherwise recognizes they are incapable of doing so, and tolls their claims until majority.

O.C.G.A. § 9-3-72, provides a discovery rule in surgical cases where a foreign object is left in the patient. Yet, a common law discovery rule is arbitrarily invoked in a score of medical injury cases not

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[15] *See*, *Welch v. Celotex Corp.*, 951 F.2d 1235 (11th Cir. 1992) (applying Georgia law); *King v. Seitzingers, Inc.*, 287 S.E.2d 252 (Ga. App. 1981).

involving foreign objects.[16] The *Kaminer* dissent and the Court of Appeals both properly recognized that new acts of negligence could result in new injuries. The majority decided that the statutes ran from the doctor's "first" negligent act and the patient's "first" and already existent injury. The word "first" is not in the statutes. The majority considered but did not apply, the "new injury" exception to the limitations period, available only in the "most extreme circumstances . . . " 653 S.E.2d at 697. *Kaminer* avoids substantive discussion of both medical and non-medical Georgia cases applying the discovery rule.

Minor patients lack the competence to discern a negligent medical act, and have no ability to ensure the protection of their rights by age seven or ten, as O.C.G.A. § 9-3-73 prescribes. The majority left Derek Canas, with no notice of a negligent act or consequent injury, as well as others similarly situated, without rights or remedies for latent medical negligence, denying them equal protection and due process of law.[17] The medical affidavit requirement for medical

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[16] *See*, n.7 *supra*.

[17] By contrast, the Indiana Supreme Court in *Martin v. Richey*, 711 N.E.2d 1273 (Ind. 1999), held that state's medical malpractice statute of limitations unconstitutional in application to an undiagnosed breast cancer patient whose disease remained latent for longer than the statutory period. "The Framers of our Constitution would have concurred with Justice Jerome Frank's Alice-in-Wonderland notion on the absurdity of applying a medical malpractice statute of limitations in cases such as this. . . ." *Id.* at 1283 n.12.

negligence[18] imposes a further barrier to a child's rights.

I. Review is Warranted Since the Challenged Statutes Violate the Fourteenth Amendment By Mandating that Minors Sue for Medical Malpractice when Georgia Law Otherwise Recognizes that Minors are Incapable of Protecting Their Own Rights, Lack the Capacity to Sue, and Have Their Claims Tolled Until Majority.

A. Georgia's Constitutionally Flawed Statutes in Historical Context.

For personal injury actions, Georgia employs a two-year limitation statute which commences when the cause of action "accrues."[19] That law embraces the concept of a continuing tort[20] and has been held not to commence until the plaintiff both discovers his or her injury and the causal connection to defendant's conduct. *See, Welch v. Celotex Corp.*, 951 F.2d 1235 (11th Cir. 1992) (applying Georgia law).

A different limitation for medical cases triggered by a negligent act appeared in Georgia in 1976, but

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[18] O.C.G.A. § 9-11-9.1.

[19] O.C.G.A. § 9-3-33.

[20] *See, Everhart v. Rich's, Inc.*, 194 S.E.2d 425 (Ga. 1972). Petitioners unsuccessfully argued that the continued failure to diagnose AIDS was a continuing tort. 639 S.E.2d at 505.

the legislation did not survive constitutional challenge in *Shessel, supra,* where the court applied a "substantial relation analysis" but commingled it with "rational basis" equal protection analysis. The court cited *Reed v. Reed,* 404 U.S. 71, 76 (1971) as support for the test applied.[21] Earlier, in *McDaniel v. Thomas,* 285 S.E.2d 156 (Ga. 1981), the court differentiated the "substantial relation to an important governmental objective" test from the "rational basis" test, suggesting clear support for heightened intermediate scrutiny equal protection analysis.[22]

In the aftermath of *Shessel,* O.C.G.A. § 9-3-71 was re-written in 1985 to start the limitation period from the date of "injury." The legislature added a new five-year "repose" provision, which, exactly like the former "limitations" statute, was triggered by a negligent act. So, the new "repose" law was conceptually identical to the constitutionally infirm "limitations" provision invalidated in *Shessel.*

O.C.G.A. § 9-3-73, enacted in 1987, imposed a laddered scheme of limitations/repose on children, requiring infants under five to sue for injuries within

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[21] *Reed* invalidated an Idaho statute and held that "a classification 'must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike.'" 404 U.S. at 76.

[22] *McDaniel* acknowledges that Georgia's equal protection and due process analysis tracks federal constitutional analysis. *Id.* at 161.

two years of their fifth birthday and a repose period tied to the tenth birthday. This law was held to trump the general tolling provision for minors' claims under O.C.G.A. § 9-3-90. *Smith,* 423 S.E.2d at 238. The repose provision was held not to toll medical negligence until discovered, and survived the equal protection challenge. The confused court also recited the words "substantial relation to the object of the legislation," only to employ the rational basis test. *Id.*[23]

When next confronted with a constitutional challenge to the repose statute, the court again upheld it. *Craven, supra,* 437 S.E.2d at 309. The 4-3 majority recognized only a two-tiered constitutional analysis, again ignored *McDaniel,* and applied the rational basis test because a patient was not in a "suspect" class. *Id.* at 310. The dissent urged intermediate scrutiny and viewed the law as unreasonable and arbitrary because acts of medical negligence might not be manifest in five years. *Id.* at 312. Had *Craven* or *Smith* acknowledged that "substantial relation" evoked "heightened intermediate scrutiny," per *McDaniel,* the statute should have failed constitutional scrutiny.

In *Kaminer*, the court provided a new arbitrary interpretation of a once irrational law by holding that in a continuum of treatment for myriad illnesses occasioned by undiagnosed AIDS, the only actionable injury occurred on the date of first misdiagnosis. The

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[23] *Accord, Crowe v. Humana,* 439 S.E.2d 654 (Ga. 1994).

holding forecloses access to the courts[24] for patients who do not discover a misdiagnosis of a latent illness or injury until more than two years have passed. The two year injury limitation subsumes the longer period of repose because Georgia courts routinely label the misdiagnosis of a latent condition the "injury" (639 S.E.2d at 512 n.21); here notwithstanding that later adverse health consequences of a deteriorating immune system are "new" injuries. Because misdiagnosis constitutes both a negligent act and injury, the longer repose period is an illusion. The construction of the three sequential statutes creates multiple classes of patients, preserving primarily patent injury and error claims.

B. The Analysis in *Smith* Should Not Have Foreclosed Constitutional Scrutiny in this Case.

Smith cannot be reconciled with the prior declaration in *Shessel* that the 1976 version of O.C.G.A. § 9-3-71 was an unconstitutional denial of equal protection because the limitation period ran from the date of the negligent act, undiscovered during the statutory period. The resultant injury in *Shessel* occurred after the period expired. The legislative relabeling of a once constitutionally infirm statute of

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[24] The denial of access to the courts is inconsistent with due process of law. *See, Morello v. James,* 810 F.2d 344 (2nd Cir. 1987; *Silver v. Cormier,* 529 F.2d 161 (10th Cir. 1976).

"limitations" as a statute of "repose" was inexplicably sufficient in *Smith* to cure the infirmity.

Smith then decided that the due process rights of children were adequately safeguarded under O.C.G.A. § 9-3-73, because a next friend or representative could bring the suit, ignoring historical precedent that a parent or next friend might neglect to protect the infant. *Sanders v. Hinton*, 156 S.E. 812, 816 (Ga. 1931). O.C.G.A. § 9-11-17(c), only requires a parent or guardian to be appointed in a child's lawsuit. It does not bridge the mandate of O.C.G.A. § 9-3-73, which forfeits the child's unknown right of action if suit is not brought within the prescribed time limitation. *Smith* overlooked O.C.G.A. § 1-2-8, which provides that minors are incapable of protecting their rights. It likewise did not discuss the impact of child's need for an expert affidavit to perfect a right of action.[25]

Other precedent undermines the *Smith* analysis: "no court before which the statute of limitations may be relied on, shall be permitted to construe it against . . . infants." *Bush v. Lindsey,* 14 Ga. 687, 688 (1854). *Barnum v. Martin,* 219 S.E.2d 341 (Ga. App. 1975), held that the limitations statute did not run against a minor even if represented by a guardian *ad litem*. The failure of a guardian to protect the interest of a minor will not operate to prejudice the minor. *Monroe v. Simmons,* 12 S.E. 643 (Ga. 1890). *Smith* does not,

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[25] O.C.G.A. § 9-11-9.1.

because it cannot, answer how children, who are incompetent and incapable of protecting their rights in other civil matters, are competent to do so in medical cases.

Finally, the decision's flawed "rational basis" equal protection analysis concludes that a separate classification for minors is rational to protect against stale claims.[26] Yet, *Clark v. Singer,* 298 S.E.2d 484 (Ga. 1983), also invalidated the former version of O.C.G.A. § 9-3-71 under the Fourteenth Amendment because it barred a wrongful death claim where the act of medical negligence occurred more than two years prior to death, since other wrongful death claims could be brought within two years of death. The law's purpose was to avoid slumbering claims by putting defendants on notice through the filing of a lawsuit within the prescribed period. *Clark* held that a claim which had not yet arisen "*has not been slumbering and is not stale.*" (Italics added.) *Id.* at 485. Cases invalidating the earlier version of O.C.G.A. § 9-3-71 and validating the current statutes provide irreconcilable constitutional analysis.

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[26] A compelling and cogent repudiation of the legislative rationale for similar statutes is found in *Hoem v. State,* 756 P.2d 780, 783 (Wyo. 1988) and *Kenyon v. Hammer,* 688 P.2d 961, 978 (Ariz. 1984).

II. Review is Warranted Because the Medical Malpractice Statutes of Limitations/Repose, As Applied, Arbitrarily and Unreasonably Denied Petitioners Due Process of Law.

Even assuming it is constitutionally permissible to abridge the rights of minors in medical malpractice cases, and override O.C.G.A. § 9-3-90, *Kaminer* is the culmination of years of arbitrary judicial statutory construction. Georgia has long recognized a cause of action in tort for aggravation of a preexisting injury.[27] A cause of action is a property right subject to Fourteenth Amendment protection,[28] as is access to the courts.[29] These concepts were lost in *Kaminer.* The word "first" appears nowhere in O.C.G.A. § 9-3-71. The statutory and common law discovery rules were ignored. The "new injury" exception is not found in the language of § 9-3-71 and applies only in "the most extreme circumstances." 653 S.E.2d at 697. This is not strict construction; it is arbitrary construction.

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[27] *See, Binns v. Metropolitan Atlanta Transit Authority*, 308 S.E.2d 674 (Ga. App. 1983), *aff'd*, 313 S.E.2d 104 (Ga. 1984); *Whatley v. Henry*, 16 S.E.2d 214 (Ga. 1941).

[28] *See, Lyon v. Agusta S.P.A.*, 252 F.3d 1078, 1086 (9th Cir. 2001); *Zavala v. United States*, 876 F.2d 780, 784 (9th Cir. 1989); *Austin v. City of Bisbee*, 855 F.2d 1429, 1435 (9th Cir. 1988).

[29] *See, e.g., Imprisoned Citizens Union v. Shapp*, 11 F. Supp. 2d 586 (E.D. Pa. 1998), *aff'd*, 169 F.3d 178 (3rd Cir. 1999).

Kaminer provides what the Indiana Supreme Court likened to an "Alice in Wonderland"[30] legal environment, preserving some patent medical claims, but stripping minors of rights without notice in latent injury cases. Not every bad decision by a state court making errors of law rises to a due process violation, but if a case is arbitrarily decided in violation of settled principles of law and contrary to disputed facts then that may violate due process under the Fourteenth Amendment.[31] If these statutes are not so vague and indefinite facially as to be void, they have been rendered so by a twenty-year hodgepodge of inconsistent holdings.

III. Review is Warranted Because the Georgia Statutes of Limitations/Repose Import a Discovery/Notice Rule in Some Cases, but Not Others, Thereby Creating Arbitrary Classes of Patients.

Had a clamp been left in Derek Canas during heart surgery in 1985 (as opposed to the HIV virus), his right of action against the surgeon would be fully

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[30] *Martin v. Richey*, 711 N.E.2d 1273, 1283 n.12 (Ind. 1999) citing *Dincher v. Martin Firearms Co.*, 198 F.2d 821, 823 (2d Cir. 1952) (Frank, J., dissenting).

[31] *Wood v. Conneaut Lake Park, Inc.* 386 F.2d 121 (3rd Cir. 1967) citing *Postal Telegraph Cable Co. v. Newport, Ky.*, 247 U.S. 464 (1918).

protected under O.C.G.A. § 9-3-72.[32] A wide range of medical cases have likewise allow some form of discovery or manifestation rule.[33] The complexities of medicine do not routinely make plain the triggering medical error. Patients cannot interpret lab results, blood work or CT scans. The doctor is the repository of the telltale medical record. This Court has recognized that a patient's ignorance of his legal rights should not prevent the running of a statute of limitations, but ignorance of the fact of his injury or its cause stands on different footing. *See, United States v. Kubrick,* 444 U.S. 111, 119-122 (1979).

This Court also held in the context of FELA, that limitations statutes are presumably not intended to attach to "blameless ignorance," but rather contemplate the assertion of claims within a specified period of time after "notice" of the invasion of legal rights. *Urie v. Thompson,* 337 U.S. 163, 170 (1949).[34] The

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[32] This statute is incorporated by reference into O.C.G.A. § 9-3-73. The previous indistinguishable version of this "foreign object" statute was held constitutional against equal protection and due process attacks in *Allrid v. Emory University,* 285 S.E.2d 521 (Ga. 1982).

[33] *See* n.7 *supra*.

[34] *Id.* at 168-171 (declining to construe statute of limitations to bar a claim which asserted that the inhalation of silica dust resulted in silicosis, because to bar the suit would be to require the claimant to file a claim during the limitations period and before the symptoms were apparent and would be to charge the claimant with knowing the "inherently unknowable," that is, "the slow and tragic disintegration of his lungs"); *see, Burgess v. United States,* 744 F.2d 771, 773 and 774 n.5 (11th Cir. 1984)

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statutes here ran in spite of blameless ignorance and in the absence of such notice. Yet, a discovery rule is applied in cancer cases to start the time running, not from when the cancer is first misdiagnosed, but from when it metastasizes.[35]

Applying a discovery rule for personal injury cases generally and for foreign object medical cases, while arbitrarily stripping that concept from selected latent medical injury cases is arbitrary and violates due process and equal protection.[36] The periods ran without notice of a negligent medical act or a doctor-caused injury.

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citing Restatement (2d) of Torts § 889 (1979) (limitation should not run where plaintiff has no knowledge of the injury) "the character of the injury will frequently prevent knowledge of what is wrong , so the plaintiff is forced to rely upon what he is told by the physician . . . ".

[35] *See, Whitaker v. Zirkle,* 374 S.E.2d 106 (Ga. App. 1988) and cases at n.7 *supra* and *Amu v. Barnes,* 650 S.E.2d 288, 292 (Ga. App. 2007) (*cert. granted*, Ga. 2008) (limitations period runs from date symptoms attributable to new injury are manifest).

[36] *See, e.g., Katz v. Children's Hosp. of Orange County*, 28 F.3d 1520 (9th Cir. 1994) (finding a portion of California's statute of limitations an unconstitutional denial of equal protection to minors and noting that the injury in this AIDS case was the discovery of that condition); *see also, Martin* (Indiana), *supra* n.17; *Carson, supra* at p. 13; *Austin, supra* n.9.

IV. Review is Warranted Because There is No Uniformity Among State and Federal Courts Concerning the Constitutionality of Similar Statutes Nor Whether Heightened Constitutional Scrutiny Should be Applied.

A. The Due Process Conflict.

Jaramillo v. Heaton, 100 P.3d 204 (N.M. Ct. App. 2004), *cert. denied*, 101 P.3d 807 (N.M. 2004), held that a medical statute of repose which required a minor subjected to malpractice before the age of six to bring a claim by the ninth birthday violated Fourteenth Amendment due process. New Mexico law also recognized that minors otherwise were incompetent or disabled until age of majority. The rationale included consideration of whether the statute accorded the minor child adequate notice and time to bring a claim.

Jaramillo noted, a parent is permitted to make the child's health care decisions, but is not required to bring a cause of action on the child's behalf. Forcing a child to bring an action by age nine, even if the child had a competent parent or guardian unreasonably did not assure time for filing suit to protect the child's rights. *Smith* employed what it called "procedural" due process analysis and reached a conclusion which is a direct contradiction to *Jarmillo's* that a conceptually

identical statute denies due process under the Fourteenth Amendment.[37]

B. The Equal Protection Conflict.

Lyons v. Lederle Laboratories, 440 N.W.2d 769 (S.D. 1989), held unconstitutional on equal protection grounds a statutory scheme which required a minor of less than six years of age to bring an action within two years of his sixth birthday, employing the rational basis test. The statutory scheme created an arbitrary classification of minors who had medical malpractice claims, as opposed to minors with any other kind of tort claim. The proffered legislative rationale for the law was substantially the same as in O.C.G.A. § 9-3-73(f). *Austin v. Litvak,* 682 P.2d 41 (Colo. 1984) held that a three-year medical malpractice statute of repose did not satisfy state rational basis equal protection analysis in latent negligent mis-diagnosis cases. It followed New Hampshire's

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[37] Federal due process requires a non-criminal statute to have language which conveys a sufficiently definite warning of the proscribed conduct when measured by common understanding and/or practice. *See, e.g., Horn v. Burns and Roe,* 536 F.2d 251, 254 (8th Cir. 1976) (citations omitted). Substantive due process is a guaranty against arbitrary or unreasonable legislation which must have a substantial relation to the object sought to be obtained. *Ingraham v. Wright,* 525 F.2d 909 (5th Cir. 1976), *aff'd,* 430 U.S. 651 (1977). Patients routinely lack notice of "negligent acts" and often suffer latent "injuries" from them. Thus, simple words in the statutes are vague and arbitrary when applied.

lead in striking a discovery statute limited to foreign object cases.

C. Other States Also Have Concluded That Similar Laws Do Not Withstand Due Process or Equal Protection Analysis.

Texas, Arizona, Utah and Ohio have all stricken similar statutes, which trump tolling provisions otherwise protecting minors, employing due process or equal protection analysis.[38] Parallel statutes are routinely justified upon the same grounds recited in O.C.G.A. § 9-3-73(f). Yet the same legislative rationale, an alleged medical malpractice crisis, protection against stale claims or rising insurance premiums etc., has been proffered and rejected.[39] A compelling

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[38] *See, Sax v. Votteler,* 648 S.W.2d 661, 666-67 (Tex. 1983); *Kenyon v. Hammer,* 688 P.2d 961, 976 (Ariz. 1984); *Lee v. Gaufin,* 867 P.2d 572 (Utah 1993); *Schwan v. Riverside Methodist Hosp.,* 452 N.E.2d 1337 (Ohio 1983); and *Mominee v. Scherbarth,* 503 N.E.2d 717 (Ohio 1986).

[39] In *Monimee v. Scherback,* 503 N.E.2d 717, 724 (Ohio 1986), citing the AMA's own survey, the court noted that average premium costs as a percentage of a physician's gross income were about 3.7% in 1983, down from 4.4% in 1976. Quoting a 15-year study of malpractice claims and premiums, the court found that the insurance industry's natural behavior contributes to the continuing cycles of "crisis" and "remission." More recently, a University of Texas collaborative study found no evidence of a crisis in that state nor any material connection between claim costs and premium fluctuations. *See,* Black, Silver, Hyman, and Sage, *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002,* 2 J. of Empirical Legal Studies, at 207 (July

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constitutional repudiation of the legislative rationales for such laws is found in *Hoem v. State*, 756 P.2d 780, 783 (Wyo. 1988). Discriminating against minors and patients subjected to latent medical errors or who suffer latent "injuries" as a consequence is not a rational way to curb the excesses of the civil justice system.[40]

D. Heightened Equal Protection Scrutiny Is Warranted for Statutes Abridging the Rights of Patients, Particularly Minor Ones, But the Statutes as Applied in this Case Fail Even Rational Basis Analysis.

In *Coburn v. Augustin,* 627 F. Supp. 983, 990-992 (D. Kan. 1995), the court struck down a Kansas statute abrogating the collateral source rule in medical

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2005): "But the more likely explanation is that much of the rise in premiums reflects insurance market dynamics, not litigation dynamics." *Id.* at 210.

[40] *See, e.g., Kenyon v. Hammer,* 688 P.2d 961, 992 (Ariz. 1984): "Arizona has neither a compelling nor legitimate interest in providing economic relief to one segment of society by depriving those who have been wronged of access to and remedy by the judicial system. If such a hypothesis were once approved, any profession, business or industry experiencing difficulty could be made the beneficiary of special legislation designed to ameliorate its economic adversity by limiting access to the courts by those who have been damaged. Under such a system, our constitutional guarantees would be gradually eroded until this state became no more than a playground for the privileged and influential."

malpractice actions only, employing heightened scrutiny equal protection analysis with respect to patients. *Coburn* cited cases applying heightened scrutiny because the laws abridged or trumped tolling provisions otherwise applicable to minors. Nevertheless, the court concluded that medical malpractice victims generally have no control over the inception of their afflictions and are relegated to a position of political powerlessness.

In *Ramos v. Town of Vernon,* 353 F.3d 171 (2d Cir. 2003), the court concluded that heightened intermediate scrutiny was required of an ordinance curtailing the rights of children.[41] The court stated:

> It bears repeating that to satisfy intermediate scrutiny, the state must show that the challenged classification serves 'important governmental objectives and that the discriminatory means employed [are] substantially related to the achievement of those objectives.' *Wengler,* 446 U.S. at 150, 100 S.Ct. 1540. In the context of minors' rights, an important governmental objective would, at the very least, address the vulnerabilities particular to minors.

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[41] Citing *Bellotti v. Baird*, 443 U.S. 622, 633 (1979), for the proposition that minors occupy a unique position in our constitutional scheme.

Id. at 180.[42] It noted that minors have no voice in the legislative process and are relegated to a position of political powerlessness. *Id.*

Lee v. Gaufin, 867 P.2d 572 (Utah 1993), applied heightened scrutiny to invalidate a medical malpractice statute which, withdrew the prior tolling protection for minors:

> Historically, the law has recognized that special rules are necessary for children. In this and other states, courts and legislatures have generally conferred a special status on minors with respect to their legal capacity to sue and be sued. Because of their lack of experience, judgment, knowledge, resources, and awareness, minors cannot effectively assert and protect their legal rights. That is especially true in the context of medical malpractice lawsuits with respect to infants who suffer physical, mental, or emotional injuries that are not apparent and cannot be discerned or communicated by the infant until he or she reaches a later stage of development and is more mature.

867 P.2d at 578. That court observed that this Court "has applied a stricter standard of scrutiny in a number of federal equal protection cases involving

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[42] This case also cites *Clark v. Jeter*, 486 U.S. 456, 461 (1988) and *Craig v. Boren*, 429 U.S. 190, 197 (1976) ("quasi-suspect" classifications or "important" rights may invoke an intermediate level of scrutiny).

the rights of children, although none involved a state medical malpractice act." *Id.* at 583.[43] *Gaufin* then reviewed the shortened limitations period which Utah's medical malpractice statutes applied to minors as follows:

> [It] not only treats minors injured by a healthcare provider categorically different from minors injured by all other defendants, but it also treats minors and adults as if they were situated the same under the law. Minors and adults are not, however, similarly situated under the law with respect to their ability to assert a claim for injuries caused by malpractice. Minors, unlike adults, have no legal capacity to sue. Their legal incapacity is based on fundamental differences between adults and minors with respect to their physical, intellectual, psychological, and judgmental maturity. If the law failed to

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[43] Citing *Plyler v. Doe*, 457 U.S. 202, 223-24 (1982) ("If the State is to deny a discrete group of innocent children [undocumented children] the free public education that it offers to other children residing within its borders, that denial must be justified by a showing that it furthers some substantial state interest."); *Lalli v. Lalli*, 439 U.S. 259, 268 (1978) ("We are asked to decide whether the discrete procedural demands that [a descent and distribution statute] places on illegitimate children bear an evident and substantial relation to the particular state interests this statute is designed to serve."); *Trimble v. Gordon*, 430 U.S. 762, 767 (1977) (scrutiny of classifications based on illegitimacy is "not a toothless one"); and *Weber v. Aetna Casualty & Sur. Co.*, 406 U.S. 164, 172 (1972) ("when state statutory classifications approach sensitive and fundamental personal rights, this Court exercises a stricter scrutiny").

> recognize those differences, the legal rights of minors could be exploited unconscionably and the law made an instrument of oppression as to the legal rights of minors.

Id. at 577. The court examined the legislation's stated purposes, including counteracting increased health care costs and physician attrition said to have resulted from increased malpractice claims and judgments. *Id.* at 583 n.17. Citing two authoritative studies,[44] it concluded that long-tail claims for injuries to minors had a comparatively minor impact on malpractice insurance costs:[45] *Id.* at 587.

In *Schwan v. Riverside Methodist Hosp.*, 452 N.E.2d 1337 (Ohio 1983), the court held that a similar statute triggered at age ten violated equal protection:

> We recognize that the General Assembly often must draw lines in legislation. Yet, it is the age of majority which establishes the

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[44] NAIC, Malpractice Claims: Final Compilation, Medical Malpractice Closed Claims, 1975-1978 (1981) and U.S. Department of HEW, Pub. No. 73-88. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice 254 (1973).

[45] *See also, Kenyon v. Hammer,* 688 P.2d 961, 978 (Ariz. 1984) (citing the same reports and finding that there was no basis for concluding rising healthcare costs had any causal connection to an increase in medical malpractice premiums.) 97% of all medical malpractice claims were reported within four years of injury. The court found no long-tail claims problem mandating the need for shorter periods of limitation; *accord, Carson, supra* at 834.

> only rational distinction . . . Therefore, in light of our conclusion that [the statute] creates an irrational classification which does not rationally further the purpose of [the legislation], we hold that [it] is unconstitutional on its face with respect to medical malpractice litigants who are minors.

452 N.E.2d at 1339.

Mominee v. Scherbarth, 503 N.E.2d 717 (Ohio 1986), then held that the statute addressed in *Schwan* also violated due process:

> [T]he sum and substance [of the statute] is that a minor shall have no standing to sue before attaining the age of majority, and no right to bring suit thereafter. Such, in our view, is totally unreasonable and patently arbitrary. The practical effect of our holding will restore the 'disabilities' tolling statute . . . for minors with malpractice claims.

Id. at 728 (citing *Shessel*). *Sax v. Votteler*, 648 S.W.2d 661, 666-67 (Tex. 1983), reached the same conclusion:

> A child has no right to bring a cause of action on his own unless disability has been removed. If a minor does bring a cause of action in his own behalf, the action is subject to being abated upon a timely plea of the defendant. If the parents, guardians, or next friends of the child negligently fail to take action in the child's behalf within the time provided by [the malpractice statute], the child is precluded from asserting his cause of

> action under that statute. (Citations omitted).

The statute, "effectively abolishes a minor's right to bring a well-established common law cause of action without providing a reasonable alternative . . . " *Id.* at 667. *Sax* noted that inherent deficiencies of the law could not be cured by the fact that parents, guardians, or next friends could assert the rights of the child because "[i]t is neither reasonable nor realistic to rely upon parents, who may themselves be minors, or who may be ignorant, lethargic, or lack concern, to bring a malpractice lawsuit within the time provided . . . " *Id.* at 666-67. The statutes challenged here have the same inherent constitutional defects.

CONCLUSION

Starting a statutory clock running on patients and children who lack the competence or the training to discover medical errors and who do not know of a doctor-caused injury cannot comport with equal protection or due process. A state legislature cannot rationally decide that minors are incompetent and incapable of protecting their rights before age of majority – and indeed precluded from doing so – and then later decide that they nevertheless must do so in medical malpractice cases. The challenged statutes trump other Georgia laws protecting the rights of minors until age of majority. They co-exist with a statutory discovery rule which obtains only in cases of

foreign object/surgery cases, and a common law one, arbitrarily applied in selected medical cases.

The Fourteenth Amendment cannot abide conceptually indistinguishable laws that satisfy the Constitution in one state and violate the Constitution in the next. Nor do statutes which deprive patients or children (or both) rights and remedies available to others conform to due process or equal protection of the law. Each of the "questions presented" has an affirmative answer. This Court should provide clarity in the law as to the rights of minors and patients under the Fourteenth Amendment. It should grant the Writ of Certiorari, and review and reverse the judgment of the Supreme Court of Georgia.

Respectfully submitted,

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APPENDIX A

Supreme Court Opinion dated October 29, 2007

653 S.E.2d 691

APPENDIX A

Supreme Court of Georgia.
KAMINER
v.
CANAS et al.
Board of Regents of the University System of Georgia
v.
Canas et al.
MCG Health, Inc.
v.
Canas et al.
Al-Jabi
v.
Canas et al.

Nos. S07G0489, S07G0566, S07G0578 and S07G0587.

Oct. 29, 2007.
Reconsideration Denied Dec. 14, 2007.

CARLEY, Justice.

In 1984, Derek Canas was born with a rare heart defect. At the age of two months, he underwent surgery at the Medical College of Georgia Hospital (Hospital). During and after the procedure, he received transfusions of whole blood and blood products. In May of 1991, Dr. Sharon Kaminer, who was an employee of the Hospital, became Canas' pediatric cardiologist. In May of 1993, Dr. Ayman Al-Jabi became his general pediatric medical care provider. Although the child displayed signs of pediatric AIDS, neither Dr. Kaminer nor Dr. Al-Jabi ever arrived at

that diagnosis. They both attributed his symptoms to his heart condition. In April of 2001, Canas was finally tested for HIV and diagnosed with AIDS. He began to receive treatment, to which he has responded favorably. His condition is the result of the blood transfusions he received at the Hospital.

On December 28, 2001, Canas brought suit against Dr. Kaminer and Dr. Al-Jabi. On February 7, 2003, he filed an amended complaint which added the Board of Regents of the University System of Georgia (Board) and MCG Health, Inc. (MCGHI) as defendants and which alleged that, in their capacities as operators of the Hospital, they were vicariously liable for Dr. Kaminer's alleged malpractice. All four defendants moved for summary judgment. The trial court granted summary judgment "on all claims for medical malpractice where the alleged negligent or wrongful act or omission occurred more than 5 years before the date on which the action was brought." However, summary judgment was denied "on all medical malpractice claims where the injury occurred within 2 years of the date this action was filed and the negligent or wrongful act or omission that caused the injury occurred within 5 years of the date this action was filed."

On appeal, the Court of Appeals affirmed, even though Dr. Kaminer and Dr. Al-Jabi initially misdiagnosed Canas' condition more than 5 years before his suit was filed. Within 2 years of the commencement of the action, the two physicians had seen Canas and persisted in their failure to diagnose his

worsening AIDS condition, and the Court of Appeals concluded that

> where a patient continues to be treated by the doctor and presents the doctor with a significant change in manifestations of his condition-additional symptoms or significantly increased symptoms – such that the standard of care would require the doctor to re-evaluate the first diagnosis, it can be a new negligent act or omission to fail to reconsider the original diagnosis and take appropriate action. . . . There is evidence . . . that after the initial misdiagnoses[,] Canas presented [Dr.] Al-Jabi and [Dr.] Kaminer with significant changes in the manifestations of his condition.

Canas v. Al-Jabi, 282 Ga.App. 764, 777(1)(a), 639 S.E.2d 494 (2006). The four defendants applied for certiorari, and we granted their petitions to determine whether the Court of Appeals erred in holding that, if a plaintiff in a misdiagnosis case presents with additional or significantly increased symptoms of the same misdiagnosed disease, the medical malpractice statute of limitations and statute of repose do not bar the plaintiff's claims.

1. With regard to the statute of limitations, "[u]nder the 1976 medical malpractice statute the time period [began] to run on the date the negligence occur[red]." *Shessel v. Stroup,* 253 Ga. 56, 57, 316 S.E.2d 155 (1984). However, that is no longer the law. After that statute was found to be unconstitutional in

Shessel, the General Assembly replaced it with current OCGA § 9-3-71(a). *See Young v. Williams,* 274 Ga. 845, 846, 560 S.E.2d 690 (2002). OCGA § 9-3-71(a) provides, in relevant part, that "an action for medical malpractice shall be brought within two years after the date on which an injury or death arising from a negligent or wrongful act or omission occurred." At the same time that the General Assembly changed the date for commencement of the two-year statute of limitations to the occurrence of "an injury or death," it enacted a new five-year statute of repose which, like the former statute of limitations, runs from "the date on which the negligent or wrongful act or omission occurred." OCGA § 9-3-71(b).

This is a case of misdiagnosis. "In most such cases, the injury begins immediately upon the misdiagnosis due to pain, suffering, or economic loss sustained by the patient from the time of the misdiagnosis until the medical problem is properly diagnosed and treated. The misdiagnosis itself is the injury and not the subsequent discovery of the proper diagnosis." [Cit.]

Frankel v. Clark, 213 Ga.App. 222, 223, 444 S.E.2d 147 (1994). Thus, in most misdiagnosis cases, the two-year statute of limitations and the five-year statute of repose begin to run simultaneously on the date that the doctor negligently failed to diagnose the condition and, thereby, injured the patient.

"[P]rescribing periods of limitation is a legislative, not a judicial, function. . . ." *Hunter, Maclean,*

Exley & Dunn v. Frame, 269 Ga. 844, 846(1), 507 S.E.2d 411 (1998). Because OCGA § 9-3-71(a) provides that the period of limitation begins to run at the time of injury, "initiating the period of limitation in a medical malpractice action [at some other point, such as] when the alleged negligence is first discovered would be contrary to the plain language of" the statute. *Crowe v. Humana,* 263 Ga. 833, 834(1), 439 S.E.2d 654 (1994). That is why the continuing treatment doctrine cannot apply in Georgia. It is inconsistent with OCGA § 9-3-71(a), since its focus is not on the date that the patient was injured by the allegedly negligent misdiagnosis. Instead, the continuing treatment doctrine provides that,

> "[i]f the treatment by the doctor is a continuing course and the patient's illness, injury or condition is of such a nature as to impose on the doctor a duty of continuous treatment and care, the statute does not commence running until treatment by the doctor for the particular disease or condition involved has terminated – unless during treatment the patient learns or should learn of negligence, in which case the statute runs from the time of discovery, actual or constructive. [Cit.]"

Williams v. Young, 247 Ga.App. 337, 340, 543 S.E.2d 737 (2000), *rev'd Young v. Williams, supra.* [T]he continuous treatment doctrine, which "deems that the *negligent act* . . . continues as long as the patient remains under the physician's care" ([cit.]), is more appropriately incorporated into a statute of limitation

that commences upon the occurrence of the negligent act. [Cits.] (Emphasis in original.)

Young v. Williams, supra at 846, 560 S.E.2d 690.

"'(T)he true test to determine when the cause of action accrued is to ascertain the time when the plaintiff could first have maintained his action to a successful result.' [Cits.]" *Allrid v. Emory Univ.*, 249 Ga. 35, 36(1)(a), 285 S.E.2d 521 (1982). With regard to Canas' claim for the misdiagnosis of his AIDS condition, he was injured and, consequently, the statute of limitations began to run, on the date that Dr. Kaminer and Dr. Al-Jabi first failed to diagnose it. *Ford v. Dove,* 218 Ga.App. 828, 830(3), 463 S.E.2d 351 (1995), overruled on other grounds, *Ezor v. Thompson,* 241 Ga.App. 275, 279(1), 526 S.E.2d 609 (1999).

The injury at the time of the misdiagnosis was that [Canas] continued to suffer from an undiagnosed and untreated [AIDS condition] that continued to slowly progress and worsen. Clearly, [Canas'] injury had occurred, and [his] cause of action had accrued, [as of the initial misdiagnoses]. The fact that [he] did not know the medical cause of these symptoms does not affect the applicability of OCGA § 9-3-71(a). In addition, the fact that these symptoms worsened . . . does not lead to a different result, as the subsequent [worsened condition] was directly related to the initial symptoms and misdiagnosis. [Cit.] The two-year statute of limitation[s] in OCGA § 9-3-71(a) commenced to run on [Canas'] medical malpractice action alleging misdiagnosis of [his AIDS condition]

from the date of [his] injury in [1991, in the case of Dr. Kaminer, and 1993, in the case of Dr. Al-Jabi] and expired prior to the date [he] filed [his complaint against them] on [December 28, 2001].

Stafford-Fox v. Jenkins, 282 Ga.App. 667, 669-670(1), 639 S.E.2d 610 (2006). "'A subjective belief that symptoms were due to some other cause unrelated to the alleged negligence does not change the point at which the injury occurred.' [Cit.]"*Ford v. Dove, supra* at 831(3), 463 S.E.2d 351.

Nevertheless, Canas contends that, when he developed the additional or significantly increased symptoms of his misdiagnosed condition and still was not treated for AIDS, he was, in effect, reinjured and the statute of limitations recommenced. However, any subsequent failure on the part of Dr. Kaminer or Dr. Al-Jabi to diagnose and treat Canas for AIDS despite the change in his condition did not inflict any new injury on him. Instead, the result of that failure was that his original injury, having now presumably worsened as the consequence of the lack of treatment stemming from the initial misdiagnoses, remained untreated and was, therefore, allowed to continue unabated. His preexisting injury was not transformed into a new injury simply because his underlying AIDS condition remained untreated notwithstanding the increase in his symptoms. Instead, the new injury that he contends he suffered was the direct proximate continuing result of the original misdiagnoses. "With proper diagnosis and treatment, the resultant problems would not have occurred; here, the misdiagnosis

and mistreatment *were* the cause of the 'injury' for which [Canas] sought recovery." (Emphasis in original) *Burt v. James,* 276 Ga.App. 370, 373, 623 S.E.2d 223 (2005). Where, as here, the patient's symptoms of his untreated condition worsen over time, "for statute of limitation[s] purposes, the 'injury' occurred at the time of the alleged misdiagnosis. [Cits.]" *Harrison v. Daly,* 268 Ga.App. 280, 284, 601 S.E.2d 771 (2004). Canas' "evidence demonstrates only that [his] existing condition was misdiagnosed and mistreated, and that condition was the same one that existed at the time [he] first sought treatment from Dr. [Kaminer and Dr. Al-Jabi]." *Kane v. Shoup,* 260 Ga.App. 723, 725(1), 580 S.E.2d 555 (2003). "If [his subsequent] symptoms were symptoms of the same injury that existed at the time of the alleged misdiagnosis, then the claim is barred by the two-year limitation[s] period." *Kitchens v. Brusman,* 280 Ga.App. 163, 165(2), 633 S.E.2d 585 (2006).

Subsequent failures on the part of Dr. Kaminer and Dr. Al-Jabi to recognize that Canas' additional or increased symptoms were indicative of AIDS may well constitute new and separate instances of professional negligence. After *Shessel* and under OCGA § 9-3-71(a), however, the statute of limitations on a medical malpractice claim no longer commences upon the occurrence of a negligent act or omission on the part of the physician. *Young v. Williams, supra.* It begins on the date of the patient's injury. Even assuming that, following the initial misdiagnoses, Dr. Kaminer and Dr. Al-Jabi were serially negligent in

failing to diagnose Canas properly, he has no viable claim for their breach of the applicable standard of medical care unless he suffered an injury as the result.

In order for a tort action to lie, there must be an injury to the plaintiff, i.e., some initiating event which is the result of the defendant's negligence and brings that wrongful conduct to light. "'Proof of negligence in the air, so to speak, will not do.' [Cit.]" [Cit.]

Cotton States Mut. Ins. Co. v. Crosby, 244 Ga. 456, 457(1), 260 S.E.2d 860 (1979). Canas had a cause of action against [Dr. Kaminer and Dr. Al-Jabi] on the day the original [misdiagnoses were made]. This was a complete cause of action. For a period of time, [the physicians] had an opportunity to [rediagnose his condition] and thereby lessen the extent of the claim which [he] could have made against [them]. This omission on the part of [Dr. Kaminer and Dr. Al-Jabi] was a failure to avoid the ultimate effect of the[ir] earlier breach[es] and a failure to mitigate their own damages. It was not an act inflicting new harm.

Jankowski v. Taylor, Bishop & Lee, 246 Ga. 804, 807(2), 273 S.E.2d 16 (1980).

As the Court of Appeals noted, it "would be absurd" to hold "as a matter of law [that] a doctor can only misdiagnose a patient once, regardless of the length of the treatment or the course of the patient's illness." *Canas v. Al-Jabi, supra* at 777(1)(a), 639 S.E.2d 494. However, the patient's injury, and not the

physician's negligence, is the determinative factor for statute of limitations purposes. A holding that the requirement of OCGA § 9-3-71(a) can be satisfied whenever the doctor persists in a negligent misdiagnosis of the same medical condition would represent an adoption by the judiciary of the continuing treatment doctrine that was rejected by the General Assembly. So long as the patient maintains a professional relationship with the same physician who initially misdiagnosed an underlying condition that thereafter worsens significantly, the statute of limitations will not commence until the error in the original diagnosis is discovered.

The General Assembly has determined that medical malpractice actions must be filed within two years of the occurrence of injury or death arising from a negligent or wrongful act or omission. [Cit.] The legislatively-prescribed statute of limitation[s] does not provide for the commencement of the period of limitation [at any other point], and the judicial branch is not empowered to engraft such a provision on to what the legislature has enacted.

Young v. Williams, supra at 847-848, 560 S.E.2d 690.

In addition to reviving the rejected continuing treatment doctrine, the holding of the Court of Appeals in this case introduces an element of unpredictability into the determination of the date that the statute of limitations commences to run on a misdiagnosis claim. A jury issue will arise in every case in

which more than two years may have elapsed since the original misdiagnosis, and there are conflicting expert opinions as to whether, within two years of filing suit, the patient's worsening symptoms were of such magnitude as to compel a rediagnosis of his condition. Thus, the viability of a statute of limitations defense in a misdiagnosis case would almost never be capable of determination as a matter of law before a trial on the merits.

Instead of unpredictability, "[i]t is desirable to have stability and certainty in the law. . . . [Cits.]" *Dowis v. Mud Slingers,* 279 Ga. 808, 811, 621 S.E.2d 413 (2005). Stability and certainty are not advanced by holding that it is possible for the statute of limitations to recommence whenever, over the course of continuing treatment, the physician negligently fails to recognize that the cause of the patient's worsening condition is different from that which was originally diagnosed. In the context of a misdiagnosis case, the plaintiff's "injury" as used in OCGA § 9-3-71(a) has long been confined to the original negligent diagnosis. *Stafford-Fox v. Jenkins, supra*; *Kitchens v. Brusman, supra*; *Burt v. James, supra*; *Harrison v. Daly, supra*; *Kane v. Shoup, supra*; *Ford v. Dove, supra. See also Young v. Williams, supra* at 846, 560 S.E.2d 690 (citing *Ford v. Dove* as authority for expressly rejecting the continuous treatment rule in medical malpractice cases); *Hunter, Maclean, Exley & Dunn v. Frame, supra* at 849(1), fn. 18, 507 S.E.2d 411 (citing *Ford v. Dove* as authority for expressly rejecting the continuing representation rule for legal malpractice).

The General Assembly has neither indicated its disapproval of that interpretation of the statute as too restrictive nor expanded it to include instances of serial misdiagnoses by the allegedly negligent doctor.

"(E)ven those who regard 'stare decisis' with something less than enthusiasm recognize that the principle has even greater weight where the precedent relates to interpretation of a statute." [Cit.] A reinterpretation of a statute after the General Assembly's implicit acceptance of the original interpretation would constitute a judicial usurpation of the legislative function.

Abernathy v. City of Albany, 269 Ga. 88, 90, 495 S.E.2d 13 (1998). *See also Hart v. Owens-Illinois,* 250 Ga. 397, 400, 297 S.E.2d 462 (1982).

As authority for its holding, the Court of Appeals cited *Oliver v. Sutton,* 246 Ga.App. 436, 540 S.E.2d 645 (2000). *Canas v. Al-Jabi, supra* at 785(1)(b), 639 S.E.2d 494. However, that case is distinguishable, as it did not involve a series of failures to diagnose the same underlying medical condition. Instead, the physician in *Oliver* committed a subsequent act of malpractice when he eventually discovered his original diagnosis was wrong and failed to communicate the proper diagnosis to the patient. "Although determining the correct diagnosis after allegedly misdiagnosing the problem is certainly not negligence, failing to communicate the proper diagnosis can be." *Oliver v. Sutton, supra* at 438, 540 S.E.2d 645. There is no dispute that Dr. Kaminer and Dr. Al-Jabi never

diagnosed Canas' AIDS condition. Thus, we do not have to decide whether, by failing to inform him that they had discovered that he had AIDS, they thereby committed a subsequent negligent act which is subject to a separate limitation period. Instead, the determinative factor here is that, after the initial misdiagnoses, Canas did not suffer any new injury during the ensuing course of continuing treatment provided by the two physicians. *Young v. Williams, supra.* By holding that the statute of limitations on Canas' claim began to run at any time other than the date of the original misdiagnoses, the Court of Appeals erroneously adopted a variant of the previously rejected continuing treatment doctrine and also erroneously failed to give effect to the long-standing interpretation given to the term "injury" as it appears in OCGA § 9-3-71(a).

2. There is a line of Court of Appeals cases in which the patient was held to have suffered a new injury subsequent to the initial diagnosis. *See Walker v. Melton,* 227 Ga.App. 149, 150, 489 S.E.2d 63 (1997); *Zechmann v. Thigpen,* 210 Ga.App. 726, 728-729(3), 437 S.E.2d 475 (1993); *Whitaker v. Zirkle,* 188 Ga.App. 706, 707(1), 374 S.E.2d 106 (1988). Canas urges that the denial of Dr. Kaminer's and Dr. Al-Jabi's motions for partial summary judgment should be affirmed under the authority of those decisions. However, those cases involve only "the most extreme circumstances . . . 'in which the plaintiff remains asymptomatic for a period of time following the misdiagnosis.' [Cit.]" *Burt v. James, supra* at 374, 623

S.E.2d 223. As the Court of Appeals noted, that line of cases is not applicable here because Canas' claim

> is premised on these alleged facts: he had AIDS at the beginning of his treatment with [Dr.] Al-Jabi and [Dr.] Kaminer; he had a medical history indicating the possibility of HIV infection; and he had symptoms of AIDS such that [Dr.] Al-Jabi and [Dr.] Kaminer should have recognized a need for further investigation. Canas did not have a more benign precursor condition; nor did he have an asymptomatic period. Instead, his untreated AIDS continuously caused his growth to be stunted, his immune system to be compromised, and his life expectancy to be diminished. Therefore, the limited "new injury" exception does not apply in this case. [Cit.]

Canas v. Al-Jabi, supra at 785(1)(b), 639 S.E.2d 494. Since the limited "new injury" line of decisions cited by Canas in support of his position "are not in any way implicated in this case under the particular fact situation presented[,] . . . this case does not present [this] Court with an appropriate vehicle to address" the continuing viability of those opinions. *Stafford-Fox v. Jenkins, supra* at 670(1), 639 S.E.2d 610.

3. The Court of Appeals did correctly hold that the statute of repose began to run on the dates that Dr. Kaminer and Dr. Al-Jabi committed their allegedly negligent acts or omissions, and that the commencement of that five-year period of limitation was not tolled until such time as they ceased to occupy the status of treating physicians. *Canas v. Al-Jabi, supra*

at 776-778(1)(a), 639 S.E.2d 494. However, the applicable dates are the same as those on which the statute of limitations started to run in 1991 and 1993, respectively, when the misdiagnoses were initially reached. Thus, the statute of repose, as well as the statute of limitations, has run on Canas' claim for the negligent failure to diagnose his AIDS condition.

4. [W]e find [OCGA § 9-3-71(a)] to be an extremely harsh limitation in application because it has the effect, in many cases, [certainly including this one,] of cutting off rights before there is any knowledge of injury. Nonetheless, the legislature has the power, within constitutional limitations, to make such provisions.

Allrid v. Emory University, supra at 37(1)(a), 285 S.E.2d 521. Accordingly, based upon the applicability of OCGA § 9-3-71(a) to the undisputed facts of this case, we are compelled to reverse the judgment of the Court of Appeals.

Judgment reversed.

All the Justices concur, except SEARS, C.J., HUNSTEIN, P.J., and THOMPSON, J., who dissent.

HUNSTEIN, Presiding Justice, dissenting.

Because I believe that the decision below both conforms to existing precedent and avoids the concededly harsh result reached by the majority, I hereby respectfully dissent.

I agree with the majority that the two-year statute of limitation applicable to those claims by Canas regarding the initial misdiagnoses by Drs. Kaminer and Al-Jabi began to run as of the date these alleged misdiagnoses were rendered. *See Stafford-Fox v. Jenkins,* 282 Ga.App. 667, 669, 639 S.E.2d 610 (2006) (for statute of limitation purposes, injury in misdiagnosis case occurs at time of misdiagnosis). However, I do not agree with the majority's holding that, as a matter of law, there can be only a single, indivisible injury flowing from serial misdiagnoses of the same condition.

As the majority notes, "[s]ubsequent failures on the part of Dr. Kaminer and Dr. Al-Jabi to recognize that Canas' additional or increased symptoms were indicative of AIDS may well constitute new and separate instances of professional negligence." Maj. Op., p. 695. The majority goes on to hold that, as a matter of law, Canas did not suffer any new injury as a result of any subsequent acts of malpractice because the deterioration in his condition was the inevitable result of his previously misdiagnosed illness. However, given that the initial injury in a misdiagnosis case is the pain and expense caused by the untreated condition, the majority opinion overlooks the possibility that there may be a separate injury after a later misdiagnosis, in the form of the continued pain and expense caused by the untreated condition which, but for the later misdiagnosis, would not have occurred. This possible factual scenario

renders inappropriate the majority's ruling as a matter of law.

Thus, in holding that subsequent misdiagnoses may constitute new acts of negligence resulting in new injury, the Court of Appeals merely recognized that, as the majority acknowledges, it is possible for a doctor to misdiagnose a patient more than once in the course of treatment, where new or more severe symptoms would, under the relevant standard of care, require a reassessment of the initial diagnosis.[1] The Court of Appeals did not, as the majority contends, effectively revive the continuing treatment doctrine, which effects an *extension* of the statute of limitation with respect to the *initial* diagnosis. *See Young v. Williams,* 274 Ga. 845, 846, 560 S.E.2d 690 (2002). Instead, the Court of Appeals simply held that a *new* act of negligence, with its concomitant *new*

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[1] This factual situation is distinguishable from that where the doctor simply fails to correct a prior misdiagnosis, the validity of which was never called into serious question by additional or enhanced symptoms. For this reason, the Court of Appeals' holding does not conflict with this Court's decision, cited by the majority, in *Jankowski v. Taylor, Bishop & Lee,* 246 Ga. 804, 273 S.E.2d 16 (1980), in which we held that the mere failure to correct a prior act of negligence was not, under the facts presented, a new act of negligence giving rise to a new claim with a new limitations period. *Id.* at 806(1), 273 S.E.2d 16. Nothing in *Jankowski* precludes our holding that subsequent instances occurring in a series of negligent acts may give rise to new actionable claims.

injury, carries with it a *new* limitations period.[2] Likewise, the Court of Appeals did not undermine "the long-standing interpretation given to the term 'injury' as it appears in OCGA § 9-3-71(a)." Maj. Op., p. 697. None of the cases cited by the majority in support of its narrow interpretation squarely addressed the issue presented in this case, that is, whether, where the patient's symptoms change or worsen so dramatically as to render the physician's continued failure to properly diagnose the patient an independent act of negligence, such subsequent misdiagnosis may be deemed to give rise to a new "injury" in the form of additional pain, suffering, and expense suffered after the subsequent misdiagnosis.

The majority justifies its notion of the single, indivisible injury as fostering "[s]tability and certainty" in the law by fixing an easily determinable date on which the statute of limitations in a misdiagnosis case will begin. Maj. Op., p. 696. However, merely because the Court of Appeals' holding might make it more difficult for medical malpractice defendants to obtain dismissal on statute of limitations grounds does not mean that it fosters unpredictability in the law. Moreover, curtailing the rights of the injured in the name of stability in the law is misguided where, as here, neither the letter nor the

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[2] Thus, the majority's assertion that under the Court of Appeals' approach, "the statute of limitations will not commence until the error in the original diagnosis is discovered," Maj. Op., p. 696, is simply incorrect.

intent of the statute in question requires such a harsh result.

In sum, I would hold that in those cases where a subsequent misdiagnosis is not merely a continuation of/failure to remedy a prior misdiagnosis but is instead (because of new or more severe symptoms that under the applicable standard of care would require a re-evaluation of the prior diagnosis) a distinct negligent act in its own right, a new injury, i.e., additional pain, suffering, and expense due to the untreated condition, has occurred, giving rise to an independent cause of action for negligence accruing on the date of the subsequent misdiagnosis. This is precisely what the Court of Appeals held, and, therefore, I would affirm.[3]

I am authorized to state that Chief Justice SEARS and Justice THOMPSON join in this dissent.

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[3] Because under this holding only negligent acts occurring within two years of the filing of the complaint would be potentially actionable, the five-year statute of repose, OCGA § 9-3-71(b), would not prevent the pursuit of claims based on such acts.

APPENDIX B

Court of Appeals Opinion dated February 26, 2007

639 S.E.2d 494

APPENDIX B

Court of Appeals of Georgia.
CANAS
v.
AL-JABI et al.
Kaminer
v.
Canas.
Al-Jabi
v.
Canas.
Board of Regents of the University System of Georgia
v.
Canas.
MCG Health, Inc.
v.
Canas.
Nos. A06A1337-A06A1341.

Nov. 20, 2006.
Reconsiderations Denied Dec. 8, 2006.
Certiorari Denied Feb. 26, 2007.

ELLINGTON, Judge.

After a hearing, the Superior Court of Glynn County granted in part and denied in part motions for summary judgment filed in Derek Canas's action against Ayman Al-Jabi, M.D., Sharon J. Kaminer, M.D., the Board of Regents of the University System of Georgia d/b/a Medical College of Georgia Hospitals

and Clinics ("the Board"), and MCG Health, Inc. ("MCGHI").[1] The trial court granted summary judgment in favor of the defendants below "on all claims for medical malpractice where the alleged negligent or wrongful act or omission occurred more than 5 years before the date on which this action was brought" and denied the motions on all other medical malpractice claims. In the same order, the trial court also denied the defendants' various motions to disqualify Canas's expert witnesses.

In Case No. A06A1337, Canas appeals the partial grant of summary judgment. Canas's direct appeal allowed the defendants to file cross-appeals of the trial court's interlocutory and evidentiary rulings.[2] In Case No. A06A1338, Kaminer appeals the partial denial of summary judgment and the order denying the motions to disqualify Canas's expert witnesses. In Case No. A06A1339, Al-Jabi appeals the partial denial of summary judgment. In Case No. A06A1340, the Board appeals the partial denial of summary judgment and the order denying the motions to disqualify Canas's expert witnesses. In Case No. A06A1341, MCGHI

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[1] When Derek Canas was seventeen years old, his parents filed this action on his behalf, initially against the two individual doctors. After Canas reached the age of majority, the trial court substituted Canas as the party plaintiff, and he now proceeds on his own behalf.

[2] OCGA § 5-6-38.

appeals the partial denial of summary judgment.[3] For the reasons that follow, we affirm.

Viewed in the light most favorable to Canas,[4] the record reveals the following facts.[5] At his birth on November 1, 1984, Canas had a rare and serious heart defect, transposition of the great arteries with total anomalous pulmonary venous return. Two months later, surgeons at the Medical College of Georgia Hospital performed surgery to correct the defect. During and after the surgery, Canas received multiple transfusions of whole blood and blood products. Before he was discharged from the hospital after the initial surgery, Canas's blood tests showed

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[3] The undisputed evidence established that before July 1, 2000, the Board operated the MCG Hospital and Clinics and employed the hospital's doctors. Beginning on that date, MCGHI began operating the MCG Hospital and Clinics; the Board continued to employ the hospital's doctors. Accordingly, "the hospital" will refer to the Board and to MCGHI collectively when we discuss issues of hospital operation that embrace dates both before and after July 1, 2000.

[4] "On appeal from the grant of summary judgment [the appellate court] conducts a de novo review of the evidence to determine whether there is a genuine issue of material fact and whether the undisputed facts, viewed in the light most favorable to the nonmoving party, warrant judgment as a matter of law." (Citation and punctuation omitted.) *Munroe v. Universal Health Svcs.*, 277 Ga. 861, 864-865(2), 596 S.E.2d 604 (2004).

[5] In Division 3, *infra*, we affirm the trial court's order denying the defendants' motions to disqualify Canas's expert witnesses. Accordingly, this recitation of facts is drawn from all of the evidence in the record, including the affidavits and deposition testimony of Canas's expert witnesses and related documentary exhibits.

anomalies which could indicate a problem with his immune system. Also before he was discharged, Canas developed a complication which required the implantation of a pacemaker. Because of his heart surgery and pacemaker, Canas required ongoing cardiology care, including regular monitoring of the pacemaker's performance and periodic modification and replacement of the pacemaker and its components.

At the time of Canas's initial surgery, in January 1985, the medical community was aware that blood from HIV-infected donors had entered the collected blood supply. With no artificial substitute for blood, however, health care providers often had no alternative to transfusing patients with potentially contaminated blood and blood products. Not long after Canas's surgery, an HIV screening test for blood donors became available. In March 1985, just two weeks after Canas was discharged, the hospital stopped using untested blood for transfusions.

On March 20, 1987, two years after Canas's initial surgery and the hospital's subsequent decision not to transfuse patients with untested blood, the United States Department of Health and Human Services, Centers for Disease Control ("CDC"), issued a Morbidity and Mortality Weekly Report ("MMWR") which stated:

> Blood banking organizations in the United States have begun "look-back" programs to identify previous recipients of blood from donors who tested positive for HIV antibody

after screening began. In one region, 70% of recipients identified through such a program had HIV antibody. However, look-back programs cannot identify all infected transfusion recipients because many infected donors may have refrained from donating or become too ill to continue to donate after HIV serologic testing of donors began.

Because "HIV-infected persons are at risk for developing AIDS or related conditions themselves and may transmit infection to others," the MMWR urged doctors to "consider offering HIV antibody testing to some patients who received transfusions between 1978 and late spring of 1985." On April 30, 1987, the CDC issued comprehensive guidelines for HIV antibody counseling and testing which formalized the recommendation about counseling transfusion recipients, as follows:

> Patients being evaluated for signs and symptoms of illness should be counseled about the diagnostic utility of HIV antibody tests, and testing should be recommended when it is judged to be clinically appropriate for diagnosis or to assist in patient management decisions. . . .
>
> Selected patients who received transfusions of blood or blood components between early 1978 and mid 1985 should be counseled about the potential risk of HIV infection and should be offered antibody testing. . . . The decision by a physician to recommend counseling and HIV antibody testing to a person

> who has received transfusions should be based on the likelihood of infection in the recipient and the likelihood of subsequent transmission from that person to others. The risk of infection is greatest for persons who received large numbers of units of components and from blood collected in an area with a high incidence of AIDS during the few years before screening was initiated.

The American Association of Blood Banks ("AABB") and the American Red Cross publicly supported the CDC's position.

On June 24, 1988, the Presidential Commission on the Human Immunodeficiency Virus Epidemic issued its report, which recommended that "[a]s soon as is practically possible, but no later than July 1, 1989, agencies which license and certify health care facilities should make a condition for licensure a program to notify all recipients of blood or blood products since 1977 of their possible exposure to HIV." In June 1989, the Technical Advisory Task Force on Blood Resources of the American Hospital Association ("AHA") issued a report to its members titled, "Blood Issues Update re: Minimizing the Risk of Transfusion-Associated HIV Infection." In that report, the AHA questioned whether a nationwide individual notification program for all transfusion recipients would address the Presidential Commission's concerns. The AHA estimated that such a program would cost hospitals $900 million to $2 billion to trace and notify approximately 30 million

recipients. The AHA suggested the following "legal considerations":

> At this point, it is far from clear that hospitals which decline to institute notification programs necessarily would be held liable to or for recipients ultimately discovered to be infected. . . .
>
> Hospitals electing to adopt or participate in a recipient notification program would not necessarily thereby increase their liability to HIV-infected recipients. On the other hand, however, individual or public communication of transfusion risk-related information could tend to increase the likelihood of suit or to advance the time of filing by recipients who learn during the program that they are HIV-infected. . . .
>
> Although it is by no means clear at this time that hospitals have a legal "duty to warn" prior transfusion recipients (either generally or individually), . . . [h]ospitals voluntarily choosing to assume responsibility for transmitting transfusion-related information likely would be held to a "reasonableness" standard. In other words, having instituted notification efforts, such hospitals presumably could be held liable for failure to exercise "due care" or make "prudent efforts" to design and implement a well thought-out program with a reasonable chance of meeting its objectives.

In this case, the Board did not implement a universal patient notification or "recall" program as recommended by the Presidential Commission; instead, it implemented a "donor look-back" program. In that program, if the hospital discovered that a past blood donor was HIV positive, then the hospital would identify all patients who had received that donor's blood or blood products and notify those patients of their possible exposure to HIV. There is no evidence the hospital ever learned that any of Canas's blood donors had been HIV positive. The hospital never contacted Canas or his family to notify them of Canas's possible exposure to HIV through the transfusions he received in January and February 1985.

In May 1991, when Canas was six years old, Kaminer, a pediatric cardiologist and Board employee, began providing his pediatric cardiology care at the hospital. By that time, Canas displayed numerous signs and symptoms consistent with HIV infection and pediatric AIDS, including stunted growth, severe dental caries which required ten tooth extractions in December 1990, herpetic gingivostomatitis (a viral gum disease), recurrent pneumonia, swollen lymph nodes, and repeated viral illnesses of obscure and undiagnosed etiology. When Kaminer began treating Canas, he measured 42.8 inches tall and weighed 37.3 pounds, in the lowest fifth percentile for boys his age.

In May 1993, when Canas was eight years old, Al-Jabi began providing his general pediatric medical care. Canas continued to display signs of pediatric

AIDS. In August 1994, when Canas was nine years old, he was hospitalized for ten days with pneumonia. He had an elevated blood sedimentation rate, the cause of which was never identified. At that time he measured 48.7 inches tall and weighed 45.2 pounds.

When Kaminer saw Canas in August 1996 when he was 11 years old, he measured 49.6 inches tall and weighed 52.7 pounds. She did not see Canas again until February 2000, when he was 15 years old, measured 50.4 inches tall and weighed 59.1 pounds. As Kaminer later acknowledged, it is one thing to be small at age five or six, but quite another at age fifteen. In the interim, Canas had developed gastrointestinal problems, particularly recurrent and unexplained diarrhea. At the February 2000 examination, Kaminer noted that Canas was experiencing shortness of breath, wheezing, and tightness in his chest. He was weak and lacked stamina; his tolerance for exercise was in the bottom tenth percentile for boys his age. Kaminer saw Canas four more times, the last time on February 15, 2001. According to Canas's parents, throughout Kaminer's treatment of Canas, she attributed Canas's growth delay to his congenital heart defect even though they asked if his failure to grow could be caused by something else. She never referred Canas to another specialist for evaluation of his stunted growth, recurrent viral illnesses, and oral sores and dental decay. Kaminer limited her care of Canas to the issue of his heart function.

Al-Jabi, Canas's pediatrician, continued to see Canas for his various illnesses through March 15,

2000 when, as Al-Jabi later conceded, the fifteen-year-old Canas had the appearance of a seven-year-old boy. Like Kaminer, Al-Jabi attributed Canas's stunted growth and frequent illnesses to his congenital heart defect and never referred him to another specialist for evaluation of those problems. According to Al-Jabi, HIV "wasn't on the radar screen" because of Canas's heart condition. Al-Jabi did not consider himself Canas's "primary care physician." Al-Jabi testified that he never performed any routine "yearly check-up" type physical examination on Canas because he only saw Canas when he was ill.

Around the time of Canas's last visit with Al-Jabi, Canas's difficulties with repeated bronchitis and pneumonia, wheezing and shortness of breath had become so severe that Canas's parents took him to be evaluated by a pulmonologist. An x-ray of Canas's forearm, ribs, and hands revealed that at age fifteen he demonstrated the bone development of a six-year-old boy. Based on this, the pulmonologist referred Canas for evaluation by an endocrinologist. For several months beginning in July 2000, Canas received shots of human growth hormone but failed to respond. The endocrinologist then referred Canas to a pediatric immunology clinic.

In April 2001, at age 16, Canas was finally tested for HIV and was diagnosed with AIDS. Since beginning high activity antiretroviral drug therapy, Canas's viral load has dropped to undetectable levels, he has grown, and he suffers fewer infectious illnesses.

Canas filed suit against Al-Jabi and Kaminer on December 28, 2001. He filed an amended complaint, adding the Board and MCGHI as defendants, on February 7, 2003. Though the amended complaint is divided into five counts, Canas asserts two main theories of recovery. First, Canas claims that Al-Jabi and Kaminer committed medical malpractice, and asserts a derivative claim under the doctrine of respondeat superior against the Board as Kaminer's employer. Second, Canas claims the Board and MCGHI (as the operators of the hospital) and Kaminer (as an agent of the hospital) failed to discharge a duty to notify patients who had received transfusions at the hospital between 1978 and the spring of 1985 that their transfusions with untested blood and blood products might have exposed them to HIV and to advise them to be tested. Canas contends that the acts forming the basis of this "administrative failure to warn" claim did not involve medical judgment and thus the claim sounds in ordinary negligence, not in medical malpractice.

All of the defendants below filed motions for summary judgment. The trial court granted summary judgment in favor of the defendants "on all claims for medical malpractice where the alleged negligent or wrongful act or omission occurred more than 5 years before the date on which this action was brought." The trial court specifically denied the motions for summary judgment "on all medical malpractice claims where the injury occurred within 2 years of the date this action was filed and the negligent or

wrongful act or omission that caused the injury occurred within 5 years of the date this action was filed." In the same order, the trial court denied the defendants' various motions to disqualify Canas's expert witnesses. In a subsequent order, the trial court made explicit a legal conclusion that was implicit in the summary judgment order, specifically that the medical malpractice statute of limitation and statute of repose, OCGA §§ 9-3-71 and 9-3-73, do not violate the due process or equal protection clauses of the United States or Georgia constitutions.[6]

1. All of the parties challenge the trial court's ruling on the appellees' motions for summary judgment as to Canas's claim for medical malpractice, as set out in Count 1 of his amended complaint.

(a) Statute of Repose

Under OCGA § 9-3-71(b), no action for medical malpractice may be brought more than five years "after the date on which the negligent or wrongful act or omission occurred." Subsection (b) "is intended to create a five-year statute of ultimate repose and abrogation." OCGA § 9-3-71(c).

Canas contends Al-Jabi, Kaminer, and the Board are not entitled to judgment as a matter of law on the basis of Georgia's five-year medical malpractice

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[6] Canas directed his appeal to the Supreme Court of Georgia on the basis of the trial court's constitutional rulings. The Supreme Court subsequently transferred the appeal and cross-appeals to this Court. *See* Division 1(a), *infra*.

statute of repose as to any aspect of his malpractice claim. Canas contends the medical malpractice statutory repose period is tolled until the injured person reaches the age of majority. If the repose period is not tolled, Canas contends the statute is unconstitutional in that it denies minors due process, equal protection, and access to the courts.

In alternative arguments, Canas contends that he filed his complaint within five years of the statute's trigger date, "the negligent or wrongful act or omission," specified in OCGA § 9-3-71(b). First, Canas contends that the date of the negligent or wrongful act or omission in a misdiagnosis case can be no earlier than the date the health care provider's treatment of the patient ends or the date the patient receives the correct diagnosis. Second, Canas contends that the date on which a negligent or wrongful act or omission occurs in cases of latent medical negligence can be no earlier than the discovery of the act or omission by the patient (or by the parents of a minor). Finally, Canas contends that under the doctrine of equitable estoppel the appellees are precluded from asserting a statute of repose defense by their fraudulent concealment of his HIV infection.

Al-Jabi, Kaminer, and the Board contend, on the other hand, that the alleged negligent or wrongful act or omission that caused Canas's injury occurred more than five years before the date this action was filed and, therefore, that the trial court erred in granting

only partial summary judgment on Canas's malpractice claim.[7] Generally, these appellees contend that in cases of an alleged misdiagnosis, such as this case, the date on which the negligent act or omission occurs is the date the physician first failed to make the correct diagnosis. According to Canas's own experts, Al-Jabi and Kaminer should have recognized Canas's symptoms of pediatric AIDS no later than 1994, when he was ten years old. Accordingly, these appellees contend, any negligent or wrongful act or omission occurred by the end of 1994, and Canas's action, filed seven years later, is precluded by the statute of repose.[8]

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[7] In part, Canas asserted a theory of derivative liability against the Board under a theory of respondeat superior for the medical malpractice allegedly committed by its employee, Kaminer. In addition, Canas claims the Board and MCGHI are directly liable for their failure to warn. As we discuss in Division 2(a), *infra*, the failure to warn claim is a claim for ordinary negligence not subject to the medical malpractice statute of repose and statute of limitation.

[8] In addition to these arguments, MCGHI contends it cannot be held derivatively liable for any malpractice committed by Kaminer because it never employed her or any other doctors. But the record shows that Canas does not seek to impose such liability. Canas did not allege in his complaint that MCGHI is liable as Kaminer's employer for her medical malpractice. Furthermore, Canas has confirmed in pleadings and arguments of counsel that he asserts liability against MCGHI only for the Board's failure to warn before July 1, 2000 (based on MCGHI's assumption of the Board's existing liabilities) and for MCGHI's own failure to warn beginning on that date when it took over operation of the hospital. *See MCG Health v. Nelson*, 270 Ga.App. 409, 411-412(1), 606 S.E.2d 576 (2004) (MCGHI

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The medical malpractice statutory repose period is not tolled until an injured minor reaches the age of majority or until the injured person discovers the negligent or wrongful act or omission. "A statute of ultimate repose sets an ultimate limit on which injuries shall be actionable." (Citation and punctuation omitted.) *Esener v. Kinsey,* 240 Ga.App. 21, 22, 522 S.E.2d 522 (1999).

> A statute of ultimate repose delineates a time period in which a right may accrue. If the injury occurs outside that period, it is not actionable. A statute of repose stands as an unyielding barrier to a plaintiff's right of action. The statute of repose is absolute. . . . The statute of repose destroys the previously existing rights so that, on the expiration of the statutory period, the cause of action no longer exists.

(Citation and punctuation omitted.) *Simmons v. Sonyika,* 279 Ga. 378, 379, 614 S.E.2d 27 (2005). In enacting a statute of repose, which abolishes a cause of action after the allotted time, legislators exercise the right to "wipe the slate clean" after a fixed period of time. *Craven v. Lowndes County Hosp. Auth.,* 263 Ga. 657, 660(2), 437 S.E.2d 308 (1993). [B]y definition, a statute of ultimate repose cannot be "tolled."

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assumed responsibility for all liabilities involving the hospital that arose before or after the July 1, 2000 transfer date). Accordingly, there is no derivative claim against MCGHI for Kaminer's malpractice currently before the trial court.

> . . . Unlike statutes of limitation, statutes of repose may not be tolled for any reason, as tolling would deprive the defendant of the certainty of the repose deadline and thereby defeat the purpose of a statute of repose. Whether by discovery, which delays the accrual of the action, or by infancy, incompetency, or fraud, which may toll the statute of limitation [as provided by statute[9]], nothing stops the abrogation of the action by the statute of repose; five years after the negligent or wrongful act or omission occurred, despite any non-discovery or any tolling, the medical malpractice action or potential action ceases to exist by abrogation of law under the statute of repose.

(Citations and punctuation omitted.) *Simmons v. Sonyika,* 279 Ga. at 380, 614 S.E.2d 27.

Georgia's medical malpractice statute of repose specifically addresses the application of the statute to children. If the child was age five or older on the date of the malpractice, the statute applies without modification and no action may be filed by or on behalf of the minor after five years from the date on which the wrongful act or omission occurred. OCGA § 9-3-73(c)(2)(B). If the negligent or wrongful act or omission occurred before the child's fifth birthday, no

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[9] *See* OCGA § 9-3-73(a) (the disabilities and exceptions prescribed in OCGA §§ 9-3-90-9-3-99 shall be applicable to actions for medical malpractice), (b) (infancy and incompetency); § 9-3-96 (fraud).

action for medical malpractice may be brought after the child's tenth birthday. OCGA § 9-3-73(c)(2)(A). It follows from these authorities that Canas's argument that the statutory repose period was tolled until he reached the age of majority or until he discovered the misdiagnosis lacks merit.

The medical malpractice statute of repose is constitutional. As noted above, Canas directed his appeal to the Supreme Court of Georgia on the basis of the trial court's rulings on his constitutional challenges to the medical malpractice statute of repose and statute of limitation. The Supreme Court transferred the appeal to this Court, noting that it "has previously upheld [OCGA §§ 9-3-71 and 9-3-73] against the same challenges as they relate to minors. *See Crowe v. Humana Hospital,* 263 Ga. 833, 439 S.E.2d 654 (1994); *Smith v. Cobb County-Kennestone Hospital,* 262 Ga. 566, 423 S.E.2d 235 (1992). Accordingly, the constitutional rulings do not invoke [the Supreme] Court's jurisdiction."[10] Thus, this appeal was

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[10] *See also Craven v. Lowndes County Hosp. Auth.*, 263 Ga. at 659-660(1), (2), 437 S.E.2d 308 (the classification created by the medical malpractice statute of repose, victims of medical malpractice who discover their injuries within five years after the negligent act or omission *versus* those who discover their injuries more than five years later, bears a rational relationship to a legitimate end of government, that is, eliminating stale claims); OCGA § 9-3-73(f) (state objectives of the Code section were "providing quality health care, assuring the availability of physicians, preventing the curtailment of medical services, stabilizing insurance and medical costs, preventing stale

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transferred because our Supreme Court deemed the constitutional issues presented merely to involve the application of established constitutional law to the facts. Because OCGA §§ 9-3-71 and 9-3-73 have previously been held constitutional against similar attacks, all of Canas's arguments challenging the constitutionality of the statutes are without merit. *Braden v. Bell,* 222 Ga.App. 144, 146(1), 473 S.E.2d 523 (1996).

A medical malpractice defendant may be equitably estopped from asserting the defense of the statute of repose if the defendant's fraud prevented the plaintiff from learning the nature and cause of the injury and bringing suit. "[B]y definition, a statute of ultimate repose cannot be tolled," even by fraud under OCGA § 9-3-96,[11] "to permit actions to be brought for injuries which did not occur until after the statutory period had expired." (Citations and punctuation omitted.) *Esener v. Kinsey,* 240 Ga.App. at 22, 522 S.E.2d 522. But a medical malpractice defendant may be equitably estopped from asserting the defense of the statute of repose if the plaintiff shows fraud by offering evidence the defendant actively concealed the negligence or, given the duty arising from the doctor-patient relationship to disclose the cause of any injury, knowingly failed to reveal the negligence to the plaintiff. *Craven v. Lowndes County Hosp. Auth.,*

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medical malpractice claims, and providing for the public safety, health, and welfare as a whole").

[11] *See* Division 1(b), *infra.*

263 Ga. at 660(3), 437 S.E.2d 308; *Esener v. Kinsey,* 240 Ga.App. at 22-23, 522 S.E.2d 522; *Bynum v. Gregory,* 215 Ga.App. 431, 434(2), 450 S.E.2d 840 (1994).

> [T]he statute of ultimate repose should not be applied to relieve a defendant of liability for injuries which occurred during the period of liability, but which were concealed from the patient by the defendant's own fraud. The statute of ultimate repose should not provide an incentive for a doctor or other medical professional to conceal his or her negligence with the assurance that after [five] years such fraudulent conduct will insulate him or her from liability. The sun never sets on fraud. . . .
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> The statute of repose is not tolled by fraud, but fraud, instead, gives rise to the doctrine of equitable estoppel, which prevents the defendant from asserting the defense of the statute of repose, because his or her own wrongful conduct gave rise to the defense and prevented the plaintiff from exercising reasonable diligence to learn the nature and cause of the injury attributable to the defendant and from bringing suit.

(Citations and punctuation omitted.) *Esener v. Kinsey,* 240 Ga.App. at 22-23, 522 S.E.2d 522. Thus, "if the evidence of defendant's fraud or other conduct on which the plaintiff reasonably relied in forbearing the bringing of a lawsuit is found by the jury to exist, then the defendant, under the doctrine of equitable estoppel, is estopped from raising the defense of the

statute of ultimate repose." *Id.* Of course, without more, "[a] mere misdiagnosis is insufficient to raise an issue of fraud." (Citation and punctuation omitted.) *Craven v. Lowndes County Hosp. Auth.*, 263 Ga. at 660(3), 437 S.E.2d at 311. *See also Hutcherson v. Obstetric etc., Assocs. of Columbus*, 247 Ga.App. 685, 688(2), 543 S.E.2d 805 (2000) (accord).

In the case at bar, there is absolutely nothing supporting an inference that either Al-Jabi or Kaminer ever knew or even suspected that Canas might have AIDS before he received that diagnosis from another doctor. Thus, Canas failed to present any evidence these doctors knowingly concealed or knowingly failed to reveal their own alleged negligence. Accordingly, Canas failed to show that Al-Jabi and Kaminer should be equitably estopped from asserting the defense of statute of repose. *Craven v. Lowndes County Hosp. Auth.*, 263 Ga. at 660(3), 437 S.E.2d 308.[12]

The determination of the date on which a medically negligent or wrongful act or omission occurs is not subject to the continuing tort or continuous treatment doctrines. In misdiagnosis cases, the negligent act or omission generally occurs when the doctor fails to make the correct diagnosis (or to recognize the

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[12] *Cf. Hutcherson v. Obstetric etc., Assocs. of Columbus*, 247 Ga.App. at 688(2), 543 S.E.2d 805; *Esener v. Kinsey*, 240 Ga.App. at 22, 522 S.E.2d 522; *Bynum v. Gregory*, 215 Ga.App. at 434(2), 450 S.E.2d 840; *Hill v. Fordham*, 186 Ga.App. 354, 357(2), 367 S.E.2d 128 (1988).

need for further diagnostic tests) when presented with a patient with an injury,[13] a patient with symptoms of a medical condition,[14] or a patient with no symptoms but with a diagnostic test indicative of a medical condition.[15]

In many cases, a patient, unaware that his or her doctor failed to make the correct diagnosis, continues in treatment with the doctor for a significant period of time. In arguing that the date of the negligent or wrongful act or omission in a misdiagnosis case can be no earlier than the date the patient receives the correct diagnosis, Canas seeks to apply the "continuing tort" doctrine to misdiagnosis cases. Under Georgia law, the continuing tort doctrine fixes the date of injury, which marks the beginning of the statutory limitation period,[16] in certain cases where a "negligent or tortious act is of a continuing nature and produces

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[13] *See, e.g., Young v. Williams,* 274 Ga. 845, 560 S.E.2d 690 (2002) (dislocated bones in foot); *Walker v. Melton,* 227 Ga.App. 149, 489 S.E.2d 63 (1997) (broken vertebra).

[14] *See, e.g., Hutcherson v. Obstetric etc., Assoc. of Columbus,* 247 Ga.App. at 688(2), 543 S.E.2d 805 (shortness of breath, edema, and irregular heartbeat); *Oliver v. Sutton,* 246 Ga.App. 436, 437, 540 S.E.2d 645 (2000) (ankle pain); *Ford v. Dove,* 218 Ga.App. 828, 830(2), 463 S.E.2d 351 (1995) (blood in urine); *Zechmann v. Thigpen,* 210 Ga.App. 726, 437 S.E.2d 475 (1993) (eye dragging).

[15] *See, e.g., Craven v. Lowndes County Hosp. Auth.,* 263 Ga. at 660(2), 437 S.E.2d 308 (biopsy of mole); *Ward v. Bergen,* 277 Ga.App. 256, 626 S.E.2d 224 (2006) (mammogram); *Whitaker v. Zirkle,* 188 Ga.App. 706, 374 S.E.2d 106 (1988) (biopsy of mole).

[16] *See* Division 1(b), *infra.*

injury in varying degrees over a period of time" such as a breach of a duty to warn of the existence of a hazard capable of producing injury. *Everhart v. Rich's,* 229 Ga. 798, 802(2), 194 S.E.2d 425 (1972) (sale of harmful goods). *See also Parker v. Vaughan,* 124 Ga.App. 300, 302-303, 183 S.E.2d 605 (1971) (foreign object left in patient's body). In such a case, "a cause of action accrues when exposure to the hazard first produces ascertainable injury" but the statutory limitation period does not begin to run "until such time as the continued tortious act producing injury is eliminated, e.g., by an appropriate warning in respect to the hazard," *Everhart v. Rich's,* 229 Ga. at 802(2), 194 S.E.2d 425, or until the plaintiff "has knowledge, or through the exercise of ordinary care could have learned, of the existence of the continuing tort." *Parker v. Vaughan,* 124 Ga.App. at 302, 183 S.E.2d 605. The continuing tort doctrine has *not* been applied, however, to fix the date of the tortious act, which marks the beginning of a statutory period of ultimate repose and abrogation.[17] To the contrary, we have rejected the argument that, after an initial misdiagnosis, a doctor's "continued failure to recognize the [patient's] problem constitute[s] a continuing tort." *Frankel v. Clark,* 213 Ga.App. 222, 223, 444 S.E.2d 147 (1994). As we have observed, in actions for medical malpractice the continuing tort doctrine

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[17] *See Waters v. Rosenbloom,* 268 Ga. 482, 483(2), 490 S.E.2d 73 (1997) (not reaching appellants' argument that Court should apply the continuing tort doctrine to the medical malpractice statute of repose).

"would nullify the intent of the General Assembly that, after five years, no medical malpractice action could be brought, even when a disability attaches to toll the running of the statute because the statute of repose abolishes any action five years after the negligent or wrongful act or omission." (Citations omitted.) *Charter Peachford Behavioral Health System v. Kohout,* 233 Ga.App. 452, 456(b), 504 S.E.2d 514 (1998) (physical precedent only).

Under the continuous treatment doctrine, the negligent act is deemed to "continue[ ] as long as the patient remains under the physician's care." *Young v. Williams,* 274 Ga. at 846, 560 S.E.2d 690. Thus, in contrast to the continuing tort doctrine, the continuous treatment doctrine pertains to the date relevant to the statute of repose, that is, the date of the negligent or wrongful act or omission.[18] Still, if the General Assembly intended for the medical malpractice statute of repose to abrogate only those medical malpractice actions filed more than five years after the date on which the negligent or wrongful act or omission occurred *and* more than five years after the date on which treatment by the health care provider ended, it

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[18] *See Young v. Williams,* 274 Ga. at 846, 560 S.E.2d 690 (suggesting in dicta that the continuous treatment doctrine is more appropriately incorporated into a limiting statute that commences upon the occurrence of the negligent act); *Eyzaguirre v. Baker,* 260 Ga.App. 53, 55(1), 579 S.E.2d 47 (2003) (pointing out in dicta that the medical malpractice statute of repose is such a limiting statute that commences upon the occurrence of the negligent act).

could have so provided. Applying the continuous treatment doctrine in actions for medical malpractice would also appear to nullify the intent of the General Assembly to abolish any medical malpractice action five years after the negligent conduct. For these reasons, Canas's argument that the statutory period of repose began running only when Al-Jabi's and Kaminer's treatment of Canas ended lacks merit.

If a health care provider commits separate negligent acts or omissions against the same patient, each negligent act or omission may be subject to a separate statutory repose period. Although, as discussed above, the determination of the date on which a medically negligent or wrongful act or omission occurs is not subject to the continuing tort or continuous treatment doctrines, that is not the same as saying that for every malpractice claim based on a failure to diagnose a patient the trigger date for the statute of repose must be the date on which a doctor first misdiagnoses the patient. As we have held, persisting in a misdiagnosis does not by itself constitute a new negligent act or omission. *Frankel v. Clark,* 213 Ga.App. at 223, 444 S.E.2d 147. On the other hand, where a patient continues to be treated by the doctor and presents the doctor with a significant change in manifestations of his condition – additional symptoms or significantly increased symptoms – such that the standard of care would require the doctor to reevaluate the first diagnosis, it can be a new negligent act or omission to fail to reconsider the original diagnosis and take appropriate action. *See Zechmann*

v. Thigpen, 210 Ga.App. at 730(4), 437 S.E.2d 475 (discussing sequential separate misdiagnoses). To hold otherwise would be to declare that as a matter of law a doctor can only misdiagnose a patient once, regardless of the length of the treatment or the course of the patient's illness. This would be absurd. It follows that if a plaintiff files suit more than five years after an initial misdiagnosis, but within five years after a later misdiagnosis which rises to the level of a new and separate negligent act or omission, only the claim for injuries arising from the first diagnosis will be abrogated by the statute of repose.

As discussed in the recitation of facts, Canas's own experts testified that Canas presented to Al-Jabi and Kaminer with hallmark symptoms of pediatric AIDS at least by 1994 and suffered harm from continuing without the proper treatment until he was diagnosed in 2001. Any medical malpractice claim arising from Al-Jabi's and Kaminer's failure to recognize in 1994 that Canas's condition might not be entirely due to his heart defect, and to take the steps which would have led to an AIDS diagnosis, are abrogated by the statute of repose, because Canas filed his complaint more than five years after the allegedly negligent acts and omissions.

There is evidence, on the other hand, that after the initial misdiagnoses Canas presented Al-Jabi and Kaminer with significant changes in the manifestations of his condition. For example, beginning in early 2000 Canas experienced shortness of breath, wheezing, tightness in his chest, repeated bronchitis and

pneumonia, and intolerance for exercise. In addition, there is evidence that in early 2000 Canas's height and weight were so low compared to the norm for boys his age that Kaminer was startled. A jury could infer that Al-Jabi and Kaminer should have reevaluated their diagnoses based on such new and different manifestations of the disease. To the extent Canas filed his complaint within five years of any such new negligent acts and omissions, his malpractice claim is not abrogated by the statute of repose.

(b) Statute of Limitation

Under OCGA § 9-3-71(a), "an action for medical malpractice shall be brought within two years after the date on which an injury or death arising from a negligent or wrongful act or omission occurred." This statute "is intended to create a two-year statute of limitations." OCGA § 9-3-71(c). "A statute of limitation has as its purpose the limiting of the time period in which an action may be brought, thereby providing a date certain after which potential defendants can no longer be held liable for claims brought on such actions. It is a procedural rule limiting the time in which a party may bring an action for a right which has already accrued." (Citations and punctuation omitted.) *Young v. Williams,* 274 Ga. at 848, 560 S.E.2d 690. *See also Craven v. Lowndes County Hosp. Auth.,* 263 Ga. at 660(2), 437 S.E.2d 308.

As in the medical malpractice statute of repose, the Code specifically addresses the application of the

statute to children and provides that the two-year limitation period applies to "all minors who have attained the age of five years." OCGA § 9-3-73(b). "A minor who has not attained the age of five years shall have two years from the date of such minor's fifth birthday within which to bring a medical malpractice action if the cause of action arose before such minor attained the age of five years." *Id.* Thus, if the injury or death arising from a negligent or wrongful act or omission occurs, and therefore the cause of action accrues, before the child's fifth birthday, the child shall have two years from his fifth birthday to bring the action. *Crowe v. Humana, Inc.* 263 Ga. at 833-834(1), 439 S.E.2d 654.

Canas contends the appellees are not entitled to judgment as a matter of law on the basis of Georgia's two-year medical malpractice statute of limitation as to any aspect of his malpractice claim. As with his arguments concerning the statute of repose, Canas contends the medical malpractice statutory limitation period is tolled until the injured person reaches the age of majority. Again, Canas contends that if the limitation period is not tolled then the statute is unconstitutional. In addition, Canas contends that, as a matter of law, his cause of action did not accrue until 2000 when Al-Jabi's and Kaminer's treatment ended and when he discovered their misdiagnoses. Canas also contends the limitation period was tolled by fraudulent concealment of the misdiagnoses.

Kaminer and the Board contend, on the other hand, that Canas's alleged injury occurred more than

two years before the date this action was filed and, therefore, that the trial court erred in granting only partial summary judgment on Canas's malpractice claim. They contend that in a misdiagnosis case, such as this, the injury occurs immediately upon misdiagnosis. Accordingly, they contend, an injury from the alleged misdiagnosis occurred by the end of 1994, and Canas's action, filed seven years later, is precluded by the statute of limitation.[19]

The medical malpractice statutory limitation period is not tolled until an injured minor reaches the age of majority. Minors are subject to the specific period of limitation provided for medical malpractice actions in OCGA §§ 9-3-71(a) and 9-3-73(b), rather than the more general tolling provision for minors set out in OCGA § 9-3-90(a). *Crowe v. Humana, Inc.*, 263 Ga. at 833-834(1), 439 S.E.2d 654; *Smith v. Cobb County-Kennestone Hosp. Auth.*, 262 Ga. at 568-571(1), (2), 423 S.E.2d 235. Canas's argument that the statutory limitation period was tolled until he reached the age of majority lacks merit.

The medical malpractice statute of limitation is constitutional. The Supreme Court of Georgia has held that the classification of minors in OCGA § 9-3-73 for purposes of the limitation of medical malpractice actions satisfies the constitutional requirements

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[19] Again, the Board joins in Kaminer's arguments to the extent Canas seeks to hold it derivatively liable for Kaminer's medical malpractice.

of equal protection. *Crowe v. Humana, Inc.*, 263 Ga. at 834(2), 439 S.E.2d 654; *Smith v. Cobb County-Kennestone Hosp. Auth.*, 262 Ga. at 570-571(1)(b), 423 S.E.2d 235. Again, Canas's argument in this regard presents no basis for us to reverse the trial court's decision. *Braden v. Bell*, 222 Ga.App. at 146(1), 473 S.E.2d 523. *See* Division 1(a), *supra*.

In medical malpractice cases, the right of action accrues on the date on which the injury arising from a negligent or wrongful act or omissions occurs. Generally, the limitation period for a tort begins to run from the date "the right of action accrues." OCGA § 9-3-33. In theory, a tort right of action may be defined as accruing at one of four points: "(I) when the defendant breaches his duty; (II) when the plaintiff is first injured; (III) when the plaintiff becomes aware of his injury; or (IV) when the plaintiff discovers the causal relationship between his injury and the defendant's breach of duty." (Citation and punctuation omitted.) *Jones v. Lamon*, 206 Ga.App. 842, 844(1), 426 S.E.2d 657 (1992). For medical malpractice actions, the General Assembly chose Point II, the date of first injury. OCGA § 9-3-71(a). *See Jones v. Lamon*, 206 Ga.App. at 844(1), 426 S.E.2d 657. "[T]he focus of OCGA § 9-3-71(a) is not the date of the negligent act [or omission] but the consequence of the defendant's acts on the plaintiff." (Citation and punctuation omitted.) *Oliver v. Sutton*, 246 Ga.App. at 437, 540 S.E.2d 645.

The medical malpractice statutory limitation period is not tolled until the injured person discovers

the negligent or wrongful act or omission. The determination of the date on which the injury arising from a misdiagnosis occurs is not subject to the continuing tort or continuous treatment doctrines. In a misdiagnosis case, the negligent act or omission typically does not cause the medical condition. The patient usually first presents to the doctor with the medical condition (infection, malignancy, injury, etc.). In the interval between the negligent misdiagnosis and the correct diagnosis, the patient does not receive the medical therapies needed for his actual condition and is harmed by the delay in needed treatment, by the receipt of unneeded medical therapies for a condition the patient does not have, or both.[20]

This Court has consistently held that, in most misdiagnosis cases, "the injury begins immediately upon the misdiagnosis due to the pain, suffering, or

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[20] *See, e.g., Kane v. Shoup,* 260 Ga.App. 723, 580 S.E.2d 555 (2003) (surgery and additional bracing needed because of delay in correcting lower jaw condition); *Hughley v. Frazier,* 254 Ga.App. 544, 562 S.E.2d 821 (2002) (physical precedent only) (unneeded surgery which left plaintiff incontinent); *Hutcherson v. Obstetric etc., Assoc. of Columbus,* 247 Ga.App. at 688(2), 543 S.E.2d 805 (death from delay in diagnosing heart attack); *Oliver v. Sutton,* 246 Ga.App. at 437, 540 S.E.2d 645 (pain from untreated osteoarthritis); *Charter Peachford Behavioral Health System v. Kohout,* 233 Ga.App. at 456(b), 504 S.E.2d 514 (physical precedent only) (unneeded psychiatric hospitalizations and therapy); *Ford v. Dove,* 218 Ga.App. at 830(3), 463 S.E.2d 351 (death from delay in diagnosing brain tumor); *Frankel v. Clark,* 213 Ga.App. at 223, 444 S.E.2d 147 (pain from untreated oral cyst under new dental bridge).

economic loss sustained by the patient from the time of the misdiagnosis until the medical problem is properly diagnosed and treated." (Citation and punctuation omitted.) *Williams v. Young,* 258 Ga.App. 821, 823, 575 S.E.2d 648 (2002). *See also Kane v. Shoup,* 260 Ga.App. 723, 580 S.E.2d 555 (2003); *Oliver v. Sutton,* 246 Ga.App. at 437, 540 S.E.2d 645.[21]

Because of this, the statutory limitation period is not tolled until the person injured by a negligent misdiagnosis discovers the cause of the injury. Indeed, the Supreme Court of Georgia has held that "initiating the period of limitation in a medical malpractice action when the alleged negligence is first discovered would be contrary to the plain language of § 9-3-71 and § 9-3-73." *Crowe v. Humana, Inc.,* 263 Ga. at 833-834(1), 439 S.E.2d 654. The fact that the plaintiff may not know the medical cause of his or her suffering on the date of the misdiagnosis does not affect the applicability of the statute of limitation, even where the plaintiff was effectively precluded from bringing suit in time because he or she could not reasonably have known that his or her legal rights had been invaded before the limitation period expired.

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[21] Our oft-repeated shorthand statement that "the misdiagnosis itself is the injury" does not mean to equate the negligent act or omission (the misdiagnosis) with the consequences of that act (the injury) but rather signifies that "the [date of the] misdiagnosis itself is [the date of the beginning of] the injury," which is deemed the date "the injury occurred" for purposes of the statute of limitation. *See, e.g., Williams v. Young,* 258 Ga.App. at 823, 575 S.E.2d 648.

Williams v. Young, 258 Ga.App. at 823, 575 S.E.2d 648; *Luem v. Johnson,* 258 Ga.App. 530, 535(2), 574 S.E.2d 835 (2002) (physical precedent only); *Charter Peachford Behavioral Health System v. Kohout,* 233 Ga.App. at 456(b), 504 S.E.2d 514 (physical precedent only); *Ford v. Dove,* 218 Ga.App. at 830(3), 463 S.E.2d 351; *Frankel v. Clark,* 213 Ga.App. at 223, 444 S.E.2d 147; *Jones v. Lamon,* 206 Ga.App. at 844(1), 426 S.E.2d 657. It follows that the continuing tort doctrine does not apply in medical malpractice misdiagnosis cases.[22] *Hughley v. Frazier,* 254 Ga.App. at 546(1), 562 S.E.2d 821 (physical precedent only).

Furthermore, the Supreme Court of Georgia has specifically rejected application of the continuous treatment or course of care theory in medical malpractice actions because

> [p]rescribing periods of limitation is a legislative, not a judicial, function. The General Assembly has determined that medical malpractice actions must be filed within two years of the occurrence of injury or death arising from a negligent or wrongful act or omission. OCGA § 9-3-71(a). The legislatively-prescribed statute of limitation does not provide for the commencement of the

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[22] As we discussed in Division 1(a), *supra*, application of the continuing tort doctrine causes the statutory limitation period to begin to run when the tortious exposure to a hazard was eliminated by an appropriate warning or when the plaintiff otherwise discovered or should have discovered the existence of the continuing tort.

> period of limitation upon the termination of the health-care provider's treatment of the patient, and the judicial branch is not empowered to engraft such a provision on to what the legislature has enacted.

(Citation and punctuation omitted.) *Young v. Williams,* 274 Ga. at 847-848, 560 S.E.2d 690.[23] For these reasons, Canas's argument that the statutory limitation period began running only when Canas discovered his injury, or when Al-Jabi's and Kaminer's treatment of him ended, lacks merit.

The medical malpractice statutory limitation period may be tolled by the defendant's fraud. OCGA § 9-3-96 provides for tolling of the limitation period by a defendant's fraud, as follows: "If the defendant or those under whom he claims are guilty of a fraud by which the plaintiff has been debarred or deterred from bringing an action, the period of limitation shall run only from the time of the plaintiff's discovery of the fraud." *See* OCGA § 9-3-73(a) (the disabilities and

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[23] We note that on remand of *Young v. Williams,* "[i]n light of the inequities inherent in cases . . . in which a patient remains under the care of one physician and the statute of limitation expires on [the patient's] claim," this Court "encourage[d] the General Assembly . . . to look into and remedy this situation by enacting a statute allowing the incorporation of the continuous treatment doctrine into the existing statute of limitation provided for in OCGA § 9-3-71. A legislative enactment to this effect would create a more just statutory scheme for this type of medical malpractice case." *Williams v. Young,* 258 Ga.App. at 824, 575 S.E.2d 648. The General Assembly has not done so.

exceptions prescribed in OCGA Title 9, Chapter 3, Article 5, which includes OCGA § 9-3-96, shall be applicable to actions for medical malpractice). Thus,

> [a]ctual fraud, through nondisclosure of a known injury or through acts to conceal the injury, which deters or debars the bringing of the action, tolls the running of the statute until discovery of the fraud. Fraud sufficient to toll the statute of limitation requires: (1) actual fraud involving moral turpitude on the part of the defendant; (2) the fraud must conceal the cause of action from the plaintiff, thereby debarring or deterring the knowing of the cause of action; and (3) the plaintiff must have exercised reasonable diligence to discover the cause of action, notwithstanding the failure to discover within the statute of limitation.

(Citations and punctuation omitted.) *Kane v. Shoup,* 260 Ga.App. at 726(2), 580 S.E.2d 555.

Furthermore, "[w]here a confidential doctor-patient relationship exists, such fraud may be constructive, and silence when there is a duty to speak can constitute fraud." (Citations and punctuation omitted.) *Kane v. Shoup*, 260 Ga.App. at 726(2), 580 S.E.2d 555. *See also Charter Peachford Behavioral Health System v. Kohout,* 233 Ga.App. at 457-458(c), 504 S.E.2d 514 (physical precedent only) (in the case of a confidential doctor-patient relationship, "concealment per se or intentional silence amounts to actual fraud that tolls the statute") (citations omitted). This rule is based upon the premise that

> [a] patient has the right to believe what he is told by his medical doctors about his condition. The statute of limitation would not begin to run if the defendant physician had assured him that the injuries which had manifested themselves were only slight or only temporary and assured him that he would eventually be all right, thereby inducing plaintiff to refrain from making any further inquiry into his condition.

(Citation and punctuation omitted.) *Hill v. Fordham,* 186 Ga.App. at 355(1), 367 S.E.2d 128. Thus, while a physician has a fiduciary duty to inform his patient of any injury or negligent mistreatment, to establish fraud a plaintiff must present evidence that the physician knew that the plaintiff was injured in the ways plaintiff contends; that the physician knew that his violations of the standard of care caused such injuries; and that he intentionally concealed such fact.

(Citations and punctuation omitted.) *Kane v. Shoup,* 260 Ga.App. at 726(2), 580 S.E.2d 555. Again, "[a] mere misdiagnosis is insufficient to raise an issue of fraud. Thus, if the defendant never learns or has no reason to believe that there has been a misdiagnosis, then there can be no concealment, because there must be the actual intent to mislead or to conceal, involving moral turpitude." (Citations and punctuation omitted.) *Charter Peachford Behavioral Health System v. Kohout,* 233 Ga.App. at 459(c), 504 S.E.2d 514 (physical precedent only). To toll the running of the statute of limitation by fraud or concealment,

plaintiff must present evidence to show such concealment or fraud by each defendant against whom such tolling is sought to apply. Even where the plaintiff can show actual fraud exists, if plaintiff knew all of the facts necessary to show malpractice prior to the running of the statute, then such knowledge will prevent the statute from being tolled.

(Citations omitted.) *Id.* at 457(c), 504 S.E.2d 514 (physical precedent only). In this case, Canas has identified no evidence that either Al-Jabi or Kaminer knew that Canas was HIV positive and suffered from AIDS, that Al-Jabi or Kaminer knew that their violations of the standard of care caused Canas not to be correctly diagnosed, and that they intentionally concealed their negligence. As a result, the statutory limitation period was not tolled as a matter of law. *Craven v. Lowndes County Hosp. Auth.*, 263 Ga. at 660(3), 437 S.E.2d 308; *Kane v. Shoup*, 260 Ga.App. at 726(2), 580 S.E.2d 555; *Hutcherson v. Obstetric etc., Assoc. of Columbus*, 247 Ga.App. at 688(2), 543 S.E.2d 805; *Charter Peachford Behavioral Health System v. Kohout*, 233 Ga.App. at 459(c), 504 S.E.2d 514 (physical precedent only); *Stone v. Radiology Svcs.*, 206 Ga.App. 851, 853(2), 426 S.E.2d 663 (1992) (physical precedent only).[24]

The determination of the date on which an injury arising from a medically negligent or wrongful act or

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[24] *Cf. Bynum v. Gregory*, 215 Ga.App. at 434(1), 450 S.E.2d 840; *Hill v. Fordham*, 186 Ga.App. at 357(2), 367 S.E.2d 128.

omission occurs may be subject to the new injury rule. Although, in most misdiagnosis cases, the actionable injury begins immediately upon the misdiagnosis, as discussed above, in some cases a patient may also suffer a new injury as a relatively benign or treatable precursor condition, which is left untreated because of the misdiagnosis, progresses to a more dangerous condition.[25]

> Georgia's appellate courts . . . have carved out a "limited exception" in cases where a misdiagnosis and failure to provide proper treatment results in the development of a new and different injury than that which existed at the time of the misdiagnosis. In those cases, the focus of OCGA § 9-3-71(a) is not on the date of the negligent act but the consequence of the defendant's acts on the plaintiff. The result is that when an injury occurs subsequent to the date of the medical treatment, the statute of limitation commences from the date the injury is discovered.

(Citations and punctuation omitted.) *Ward v. Bergen,* 277 Ga.App. at 258-259, 626 S.E.2d 224. This

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[25] *See, e.g., Ward v. Bergen,* 277 Ga.App. 256, 626 S.E.2d 224 (localized precancerous growths progressed to metastatic breast cancer); *Walker v. Melton,* 227 Ga.App. 149, 489 S.E.2d 63 (a minor vertebral fracture progressed to worsened vertebral compression, failure of a spinal ligament, and destabilization of the spine); *Zechmann v. Thigpen,* 210 Ga.App. 726, 437 S.E.2d 475 (a minor eye condition progressed to glaucoma and destruction of the eye); *Whitaker v. Zirkle,* 188 Ga.App. 706, 374 S.E.2d 106 (a malignant mole progressed to metastatic melanoma).

limited exception has the effect of changing the date the injury occurs in certain cases of misdiagnosis, such that a claim will survive a statute of limitation challenge even though the plaintiff files the complaint more than two years after the misdiagnosis.[26] *See Jones v. Lamon,* 206 Ga.App. at 846(1), 426 S.E.2d 657 (criticizing *Whitaker v. Zirkle,* 188 Ga.App. 706, 374 S.E.2d 106 (1988), in which exception was created).

This limited exception applies only "in the most extreme circumstances" and "is confined to those cases in which the plaintiff remains asymptomatic for a period of time following the misdiagnosis." *Burt v. James,* 276 Ga.App. 370, 374, 623 S.E.2d 223 (2005).[27] But the exception does not apply where the plaintiff's condition remains "fairly constant," even though the patient's symptoms "may have been more painful, more extensive, and more debilitating [later;] . . . that [is] a matter of degree." *Burt v. James,* 276 Ga.App.

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[26] We note that the exception does not "toll" the statutory repose period. A claim filed more than five years after the negligent act or omission of the misdiagnosis may fall to a statute of repose challenge, regardless of the new injury exception. *Zechmann v. Thigpen,* 210 Ga.App. at 730(4), 437 S.E.2d 475.

[27] See also *Ward v. Bergen,* 277 Ga.App. 256, 626 S.E.2d 224 (four years after positive mammogram before another mammogram revealed the metastatic cancer); *Walker v. Melton,* 227 Ga.App. 149, 489 S.E.2d 63 (18 months without back pain); *Zechmann v. Thigpen,* 210 Ga.App. at 729(3), 437 S.E.2d 475 (four years before eye pain appeared); *Whitaker v. Zirkle,* 188 Ga.App. 706, 374 S.E.2d 106 (seven years before cancer symptoms appeared).

at 373, 623 S.E.2d 223 (pain immediately after back surgery).[28]

Canas's case is premised on these alleged facts: he had AIDS at the beginning of his treatment with Al-Jabi and Kaminer; he had a medical history indicating the possibility of HIV infection; and he had symptoms of AIDS such that Al-Jabi and Kaminer should have recognized a need for further investigation. Canas did not have a more benign precursor condition; nor did he have an asymptomatic period. Instead, his untreated AIDS continuously caused his growth to be stunted, his immune system to be compromised, and his life expectancy to be diminished. Therefore, the limited "new injury" exception does not apply in this case. *Williams v. Young,* 258 Ga.App. at 824, 575 S.E.2d 648.

If a health care provider commits separate negligent acts or omissions against the same patient, each negligent act or omission may be subject to a separate statutory limitation period. As with the statute of repose analysis, *see* Division 1(a), *supra,* a patient

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[28] See also *Brahn v. Young,* 265 Ga.App. 705, 708(2), 595 S.E.2d 553 (2004) (plaintiff experienced postoperative complications immediately after surgery); *Williams v. Young,* 258 Ga.App. at 824, 575 S.E.2d 648 (plaintiff experienced symptoms continuously throughout doctor's treatment); *Charter Peachford Behavioral Health System v. Kohout,* 233 Ga.App. at 461(e), 504 S.E.2d 514 (physical precedent only) (same); *Stone v. Radiology Svcs.,* 206 Ga.App. at 853(2), 426 S.E.2d 663 (physical precedent only) (plaintiff was already suffering from effects of a brain tumor when he was misdiagnosed).

who continues in treatment after one misdiagnosis may experience separate later acts of negligence where the doctor persists in the misdiagnosis after the patient presents the doctor with a significant change in manifestations of his condition. *See Oliver v. Sutton,* 246 Ga.App. at 438, 540 S.E.2d 645 (doctor's failure to communicate a corrected diagnosis constituted a separate act of negligence from the original misdiagnosis). Because an effect logically cannot occur before its cause, the injury from the new negligent act or omission cannot be deemed to have occurred any earlier than the date of the new misdiagnosis. It follows that, if a plaintiff files suit more than two years after an initial misdiagnosis, but within two years after a later misdiagnosis which rises to the level of a new negligent act or omission, only the claim for injuries arising from the first diagnosis will be barred by the statute of limitation.

As discussed above, Canas claims that Al-Jabi and Kaminer should have recognized by 1994 that his condition might not be entirely due to his heart defect and should have taken the steps which would have led to an AIDS diagnosis. In addition to being abrogated by the statute of repose, *see* Division 1(a), *supra*, Canas's claims based on his failure to be treated between 1994 and his diagnosis in 2001 are also barred by the statute of limitation because he filed his complaint more than two years after the injury, which began (and therefore occurred for purposes of the statute) on the day of the initial misdiagnosis.

But, again, there is evidence that after the initial misdiagnoses Canas presented Al-Jabi and Kaminer with significant changes in the manifestations of his condition such that a jury could infer that Canas was injured as a result of new and separate negligent acts or omissions. To the extent Canas filed his complaint within two years after such injury occurred, his medical malpractice claim is not barred by the statute of limitation. *See* Division 1(a), *supra*.

2. Kaminer, the Board, and MCGHI contend they are entitled to judgment as a matter of law on Canas's failure to warn claim.[29]

(a) With regard to Canas's claim that the Board and its successor MCGHI breached a duty to notify him that he was at high risk for HIV infection because he was transfused with untested blood, the Board and MCGHI contend the claim is one for medical malpractice, and not one for ordinary negligence.

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[29] The trial court's order did not explicitly address the parties' arguments regarding whether all of Canas's claims are properly deemed claims for medical malpractice, subject to OCGA §§ 9-3-71 and 9-3-73. Thus, it is not clear from the order whether the trial court considered all of Canas's claims to be claims for medical malpractice, or whether the trial court simply failed to dispose of the appellees' motions with regard to any ordinary negligence or fraud claims asserted. The record clearly shows, however, that the parties' contentions were before the trial court when ruling on the motions for summary judgment. Because our review of the trial court's order granting partial summary judgment is de novo, *Latson v. Boaz*, 278 Ga. 113, 598 S.E.2d 485 (2004), we address the issue on appeal.

As a result, these appellees contend, they are entitled to summary judgment under the medical malpractice statute of repose and statute of limitation. *See* Division 1, *supra*. We disagree.

Under OCGA § 9-3-70, the term "action for medical malpractice" means any claim for damages resulting from the death of or injury to any person arising out of:

> (1) Health, medical, dental, or surgical service, diagnosis, prescription, treatment, or care rendered by a person authorized by law to perform such service or by any person acting under the supervision and control of the lawfully authorized person; or
>
> (2) Care or service rendered by any public or private hospital, nursing home, clinic, hospital authority, facility, or institution, or by any officer, agent, or employee thereof acting within the scope of his employment.

The statutory definition plainly contemplates the viability of a medical malpractice claim against a hospital directly *as an institution* for negligent medical care or medical services, as distinct from a derivative claim based on respondeat superior liability for the malpractice of a hospital's agents and employees. *See Bradway v. American Nat. Red Cross,* 263 Ga. 19, 21, 426 S.E.2d 849 (1993) (malpractice claim against not-for-profit blood bank); *Frieson v. South Fulton Med. Center,* 255 Ga.App. 217, 218, 564 S.E.2d 821 (2002) (malpractice claim against a hospital); *Shirley*

v. Hosp. Auth. of Valdosta/Lowndes County, 263 Ga.App. 408, 409(1), 587 S.E.2d 873 (2003) (same); *Moore v. Louis Smith Mem. Hosp.,* 216 Ga.App. 299, 454 S.E.2d 190 (1995) (malpractice action against a nursing home).[30]

Although the term "medical malpractice" embraces care or service rendered by a hospital, however, "[s]imply because an alleged injury occurs in a hospital setting, a suit to recover for that injury is not necessarily a 'medical malpractice' action. Likewise, not every suit which calls into question the conduct of one who happens to be a medical professional is a 'medical malpractice' action." (Citations and punctuation omitted.) *Jones v. Bates,* 261 Ga. 240, 242(2), 403 S.E.2d 804 (1991). *See also Moore v. Louis Smith Mem. Hosp.,* 216 Ga.App. at 299, 454 S.E.2d 190 (rejecting the argument that any cause of action arising out of care provided by a health care facility is automatically one for medical malpractice).

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[30] *But see Lamb v. Candler Gen. Hosp.,* 262 Ga. 70, 72(2), 413 S.E.2d 720 (1992) (a hospital is not "a professional," and, therefore, a claim against a hospital is not one involving medical malpractice, subject to OCGA § 9-11-9.1); *Upson County Hosp. v. Head,* 246 Ga.App. 386, 389(1), 540 S.E.2d 626 (2000) (a hospital is not "a professional," and, therefore, a claim against a hospital is for medical malpractice, subject to OCGA § 9-11-9.1, only when liability is based upon respondeat superior and is grounded upon acts or omissions requiring the exercise of professional skill and judgment by agents or employees who are legally classified as professionals).

Whether an action alleges professional negligence or simple negligence depends on whether the professional's alleged negligence required the exercise of professional judgment and skill. . . . A professional negligence [or professional malpractice] claim calls into question the conduct of the professional in his area of expertise. . . . [I]f a claim of negligence goes to the propriety of a professional decision[,] rather than to the efficacy of conduct in the carrying out of a decision previously made, the claim sounds in professional malpractice.

(Citation and punctuation omitted.) *MCG Health, Inc. v. Casey,* 269 Ga.App. 125, 128, 603 S.E.2d 438 (2004). "Medical malpractice exists only where the act or omission by the professional requires the exercise of expert medical judgment." (Citations omitted.) *Jones v. Bates,* 261 Ga. at 242(2), 403 S.E.2d 804. Where the care or service that allegedly resulted in the plaintiff's injury is "by [its] very nature" medical care or a medical service involving medical knowledge and judgment, the claim is one for malpractice. *Bradway v. American Nat. Red Cross,* 263 Ga. at 21, 426 S.E.2d 849. In other words, to decide whether a claim is one for medical malpractice, the trial court must determine whether the case involves a "medical question." (Footnote omitted.) *Shirley v. Hosp. Auth. of Valdosta/Lowndes County,* 263 Ga.App. at 409(1), 587 S.E.2d 873. "Medical questions" have been defined as those concerning highly specialized expert knowledge with respect to which a layman can have no knowledge at

all, and the court and jury must be dependent on expert evidence. Examples of medical questions include cases where the plaintiff alleges the use of inappropriate medication, wrongful administration of medication, or failure to properly assess the degree of support required by a patient.

(Punctuation and footnotes omitted.) *Id.* at 409(1), 587 S.E.2d 873.

On the other hand, "[a]dministrative, clerical, or routine acts demanding no special expertise fall in the realm of simple negligence." (Citation and punctuation omitted.) *MCG Health, Inc. v. Casey,* 269 Ga.App. at 128, 603 S.E.2d 438. For example, a claim that a hospital failed to have appropriate equipment is one for ordinary negligence. *Jenkins County Hosp. Auth. v. Landrum,* 206 Ga.App. 753, 426 S.E.2d 572 (1992); *Candler Gen. Hosp. v. McNorrill,* 182 Ga.App. 107, 109-110(2), 354 S.E.2d 872 (1987).[31] In addition, a claim which alleges a violation of a general duty of care, rather than "a standard of care peculiar to a professional," is not a claim for medical malpractice. *Boggs v. Bosley Med. Institute,* 228 Ga.App. 598, 600(1)(a), 492 S.E.2d 264 (1997).[32] Essentially, when

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[31] *See also Sood v. Smeigh,* 259 Ga.App. 490, 494-495(1), 578 S.E.2d 158 (2003) (a surgeon's "mechanical act" of reassembling a prosthetic knee joint required merely complying with the instructions of the manufacturer, rather than the exercise of professional knowledge and skill).

[32] For example, because "[i]t is improper for *any person* to defraud another[,] as that is a standard of society from which no one is excepted[,]" a doctor's duty not to defraud his patients

(Continued on following page)

"the decisive factor in the injury forming the basis" of a plaintiff's complaint "was not a medical misjudgment," the claim is for ordinary negligence. *Candler Gen. Hosp. v. McNorrill,* 182 Ga.App. at 109-110(2), 354 S.E.2d 872.

"[W]e must look to the substance of an action against a medical professional, hospital, or health care facility in determining whether the action is one for professional or simple negligence." *Moore v. Louis Smith Mem. Hosp.,* 216 Ga.App. at 299, 454 S.E.2d 190. The issue of whether a claim is one for professional or simple negligence is a question of law for the court, to be decided based "only [on] the allegations in the complaint construed most favorably to [the plaintiff], even if other less favorable constructions are possible." *Brown v. Tift County Hosp. Auth.,* 280 Ga.App. 847, 850, n. 3, 635 S.E.2d 184 (2006). *See also Jones v. Bates,* 261 Ga. at 242(2), n. 4, 403 S.E.2d 804 (the issue of whether a claim sounds in professional malpractice or simple negligence "is resolved based on the status of the pleadings"); *MCG Health, Inc. v. Casey,* 269 Ga.App. at 128, 603 S.E.2d 438 (the issue is a question of law for the court).

The Board and MCGHI contend Canas's failure to warn claim is one for medical malpractice because

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does not arise by virtue of the doctor's "specialized expertise or his status as a professional." (Citation and punctuation omitted; emphasis in original.) *Boggs v. Bosley Med. Institute,* 228 Ga.App. at 600(1)(a), 492 S.E.2d 264. As a result, a fraud claim against a doctor is not a claim for malpractice, even where the fraud concerned the medical treatment itself. *Id.*

"the various alleged administrative failures all necessitated the use of medical judgment," relying on *Bradway v. American Nat. Red Cross,* 263 Ga. at 21, 426 S.E.2d 849. In *Bradway,* the plaintiff, who was infected with HIV by a transfusion, claimed that the Red Cross negligently failed to ask screening questions of blood donors that would allow it to identify and eliminate donors at high risk of being HIV infected. *Id.* at 22, 426 S.E.2d 849. The Supreme Court of Georgia found that the steps involved in the collection, processing, and distribution of blood constituted a professional medical service. *Id.* at 21, 426 S.E.2d 849. The Court concluded that the plaintiff's claim was one for malpractice under OCGA § 9-3-70 because the questions designed to screen out unsuitable donors were the product of medical knowledge and judgment. *Id.* at 21-22, 426 S.E.2d 849.[33]

Canas's claim, however, is fundamentally different. In *Bradway,* the allegedly negligent conduct was identifying the types of information from a donor's medical history which were required to determine whether the donor's blood was likely to be infected with HIV. This is a medical question, and a jury could have inferred that the blood bank's failure to ask

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[33] *Cf. Weiner v. Lenox Hill Hosp.,* 88 N.Y.2d 784, 650 N.Y.S.2d 629, 673 N.E.2d 914, 916-917 (1996) (claim against hospital based on inadequacy of blood testing and screening procedures was one for simple negligence because the allegedly negligent conduct did not bear a substantial relationship to the rendition of medical treatment to a particular patient).

certain questions represented a medical misjudgment. In this case, the decisive factor in the injury forming the basis of Canas's claim was the hospital's decision not to notify its patients who had received untested blood of the resulting risk of HIV infection. The hospital's decision in March 1985 to stop using untested blood for transfusions demonstrated the hospital's awareness that transfusing patients with untested blood exposed patients to an unacceptable risk of HIV transmission. Thus, the hospital had already made the medical judgment that using untested blood carried an unacceptable risk of infecting recipients with HIV. Highly specialized expert knowledge was not required to grasp this fact; it was accessible to a layman. Further, there is no evidence in the record that the hospital's decision not to notify transfusion recipients of their possible exposure to HIV represented a medical judgment that the unfortunate few, like Canas, who had been infected as a result of their transfusions would be medically benefitted by remaining ignorant of their exposure. Rather, evidence in the record suggests that the decision not to notify the hospital's transfusion recipients was made by administrators based on concerns about the expense, logistical complexity, and legal implications of such a patient notification program. There is evidence in the record which supports an inference that this aspect of hospital operations was not required to be performed by a person with medical training or that it involved the exercise of medical judgment or required medical expertise. *See Doe v. Vanderbilt Univ.*, 958 S.W.2d 117, 121-122 (Tenn.App.1997) (claim

based on university hospital's failure in 1987 and 1988 to individually notify patients who received blood transfusions prior to March 1985 that the blood they received had not been tested for HIV was not a medical malpractice claim; there was evidence that the administrative complexities and costs associated with a notification program were outside the purview of the hospital's doctors).[34] As in *Doe,* the challenged conduct was not diagnosis or treatment; the challenged conduct was the decision not to notify transfusion recipients. Furthermore, if the hospital had adopted a notification program, searching hospital records to identify recipients of transfusions during the relevant time period and mailing notices to them would have been administrative, clerical, or routine acts demanding no professional expertise.

Because Canas's failure to warn claim was based on ordinary rather than professional negligence, it is not subject to the medical malpractice statute of repose and statute of limitation. Instead, the claim is subject to the general personal injury statute, OCGA § 9-3-33, which provides that actions shall be brought within two years after the right of action accrues. As distinguished from the medical malpractice statutes, the general personal injury limitation period is tolled

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[34] *But see Smith v. American Red Cross,* 886 F.Supp. 1494, 1499 (E.D.Mo. 1995) (blood bank's donor "lookback procedure involve[d] medical expertise and judgment at every stage[,] including the determination of when to initiate such procedure, the formulation of the procedure, and the execution of same").

until the plaintiff reaches the age of majority. OCGA § 9-3-90(a); *Hart v. Appling County School Bd.*, 266 Ga.App. 300, n. 2, 597 S.E.2d 462 (2004) (physical precedent only); *Mitchell v. Hamilton*, 228 Ga.App. 850, 852(3), 493 S.E.2d 41 (1997). Because the cause of action accrued while Canas was a minor, the limitation period was tolled until November 1, 2002, the day on which he turned eighteen.[35] Canas instituted his action against all defendants before the limitation period expired. As a result, the Board and MCGHI are not entitled to judgment as a matter of law on Canas's failure to warn claim on the basis that it was not timely filed. *Jones v. Bates*, 261 Ga. at 242(2), 403 S.E.2d 804; *Moore v. Louis Smith Mem. Hosp.*, 216 Ga.App. at 299, 454 S.E.2d 190.

(b) MCGHI contends Canas did not suffer any injury after July 1, 2000, when MCGHI took over operation of the hospital. As a result, MCGHI contends, it is entitled to judgment as a matter of law because it could not have proximately caused any of Canas's injuries. The evidence, however, does not demand a finding that Canas suffered no harm after that date. Accordingly, this argument lacks merit.

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[35] In addition, the continuing tort doctrine applies outside the context of medical malpractice. *See, e.g., Miles v. Ashland Chemical Co.*, 261 Ga. 726, 727, 410 S.E.2d 290 (1991) (continuing tort doctrine); *Everhart v. Rich's*, 229 Ga. at 802(2), 194 S.E.2d 425 (same).

(c) Kaminer contends Canas's claim that, as the Board's and MCGHI's agent, she breached an "administrative" duty to warn was embraced in his claim for medical malpractice. As a result, Kaminer contends, she is entitled to summary judgment under the medical malpractice statute of repose and statute of limitation. In this instance, we agree. It is undisputed that Kaminer did not participate in or order any transfusion of untested blood; rather, the evidence shows that Canas acquired HIV from a transfusion years before Kaminer started treating him. We find no basis for concluding that Kaminer individually had an administrative duty to notify the hospital's transfusion recipients of their possible exposure to HIV. The undisputed evidence indicates that Kaminer's failure to appreciate that Canas needed to be tested for HIV resulted from her focus on the single question of whether his heart and pacemaker were performing satisfactorily. To the extent this failure means that Kaminer's care fell below the standard of care, an issue for the finder of fact, it was a *medical* misjudgment. Accordingly, Canas's failure to warn claim against Kaminer is embraced within his claim against her for medical malpractice. *See* Division 1, *supra*.

(d) The Board contends its decision not to notify patients who received transfusions between 1978 and 1985 of the risk they had received blood products from donors infected with HIV was a discretionary function. As a result, the Board contends, Canas's failure to warn claim is barred by the doctrine

of sovereign immunity. The Board, however, failed to show that this argument was presented to the trial court for consideration. Because Canas did not have an opportunity to respond to this argument in the lower court, the issue is not properly before us on appeal.

3. Qualification of Experts

Kaminer and the Board appeal the trial court's ruling denying their motions to disqualify Canas's expert witnesses. "The issue of the admissibility or exclusion of expert testimony rests in the broad discretion of the court, and[,] consequently, the trial court's ruling thereon cannot be reversed absent an abuse of discretion." (Footnote omitted.) *Cotten v. Phillips,* 280 Ga.App. 280, 283, 633 S.E.2d 655 (2006).

(a) Roger A. Williams, M.D.

Canas presented the testimony of Roger A. Williams, M.D., as to his opinion, inter alia, that the hospital was negligent as a matter of administrative policy in failing by 1987 to implement either a universal patient notification program for all patients transfused at the hospital from 1978 to 1985 *or* a focused patient notification program which would have targeted patients transfused during that period who had other risk factors (e.g., having received many units of blood or blood products). Williams also criticized the hospital's communications and record keeping practices. In denying the motions to disqualify

Williams, the trial court applied OCGA § 24-9-67.1(b),[36] which addresses expert testimony generally.

On appeal, the Board contends that the trial court's conclusion that Williams's testimony satisfied the requirements of OCGA § 24-9-67.1(b) was clearly erroneous and, therefore, that the trial court abused its discretion in denying its motion to disqualify Williams. Specifically, the Board contends Williams's testimony failed the third requirement of OCGA § 24-9-67.1(b), that the expert "applied [reliable] principles and methods reliably to the facts of the case," because two of the sources he identified, the Centers for Disease Control and the Public Health Service, did not in fact recommend notification of all patients transfused between 1977 and 1985, and because the report of the third source, the Presidential Commission on

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[36] OCGA § 24-9-67.1(b) provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact in any cause of action to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise, if:
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> (1) The testimony is based upon sufficient facts or data which are or will be admitted into evidence at the hearing or trial;
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> (2) The testimony is the product of reliable principles and methods; and
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> (3) The witness has applied the principles and methods reliably to the facts of the case.

the Human Immunodeficiency Virus Epidemic, "cannot be considered medical literature."

Viewing Williams's testimony as a whole, the trial court was authorized to conclude that he applied reliable principles and methods reliably to the facts of the case. *See Moran v. Kia Motors America,* 276 Ga.App. 96, 98(1), 622 S.E.2d 439 (2005) (factors relevant to analysis under OCGA § 24-9-67.1(b) include "whether the specialized theory or technique has been or can be tested, the theory's general acceptance in the expert community, rate of error, and peer review"). Further, through cross-examination, the appellees have tested and may continue to test Williams's application of the authorities upon which he relies to the facts of the case. We cannot say that the trial court manifestly abused its discretion in ruling that the testimony is reliable enough to be admitted under OCGA § 24-9-67.1(b). *See Moran v. Kia Motors America,* 276 Ga.App. at 98(1), 622 S.E.2d 439.

(b) Steven L. Shore, M.D.

Steven L. Shore, M.D., testified, inter alia, as to his opinion that the hospital was negligent in failing to implement a patient notification program by 1988 and in failing to maintain appropriate records regarding Canas's transfusion history, including related blood test results, and dental surgery.

Citing OCGA § 24-9-67.1(c)(2)(A),[37] the Board contends

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[37] In full, OCGA § 24-9-67.1(c) provides:

Notwithstanding the provisions of subsection (b) of this Code section and any other provision of law which might be construed to the contrary, in professional malpractice actions, the opinions of an expert, who is otherwise qualified as to the acceptable standard of conduct of the professional whose conduct is at issue, shall be admissible only if, at the time the act or omission is alleged to have occurred, such expert:

(1) as licensed by an appropriate regulatory agency to practice his or her profession in the state in which such expert was practicing or teaching in the profession at such time; and

(2) In the case of a medical malpractice action, had actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given as the result of having been regularly engaged in:

(A) The active practice of such area of specialty of his or her profession for at least three of the last five years, with sufficient frequency to establish an appropriate level of knowledge, as determined by the judge, in performing the procedure, diagnosing the condition, or rendering the treatment which is alleged to have been performed or rendered negligently by the defendant whose conduct is at issue; or

(B) The teaching of his or her profession for at least three of the last five years as an employed member of the faculty of an educational institution accredited in the teaching of such profession, with sufficient frequency to establish an appropriate level of knowledge, as determined by the judge, in teaching others how to perform the procedure, diagnose the condition, or render the treatment which is alleged to have been performed

(Continued on following page)

that, because Shore is not regularly engaged in the active practice of "hematology, pathology, blood banking, or hospital administration, which are the pertinent practice areas for issues regarding notification of transfusion recipients about the risk of contracting

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or rendered negligently by the defendant whose conduct is at issue; and

(C) Except as provided in subparagraph (D) of this paragraph:

(i) Is a member of the same profession;

(ii) Is a medical doctor testifying as to the standard of care of a defendant who is a doctor of osteopathy; or

(iii) Is a doctor of osteopathy testifying as to the standard of care of a defendant who is a medical doctor; and

(D) Notwithstanding any other provision of this Code section, an expert who is a physician and, as a result of having, during at least three of the last five years immediately preceding the time the act or omission is alleged to have occurred, supervised, taught, or instructed nurses, nurse practitioners, certified registered nurse anesthetists, nurse midwives, physician's assistants, physical therapists, occupational therapists, or medical support staff, has knowledge of the standard of care of that health care provider under the circumstances at issue shall be competent to testify as to the standard of that health care provider. However, a nurse, nurse practitioner, certified registered nurse anesthetist, nurse midwife, physician's assistant, physical therapist, occupational therapist, or medical support staff shall not be competent to testify as to the standard of care of a physician.

AIDS through transmission of HIV," Shore was not qualified "as a blood banking expert" to testify regarding such issues. In response to this argument, Canas contends that a portion of Shore's testimony concerns "the hospital's administrative performance" and not its professional medical duties and services, and, therefore, that the testimony was subject to the less restrictive standards of OCGA § 24-9-67.1(b). *See* Division 2(a), *supra*. We agree that OCGA § 24-9-67.1(b) applies to Shore's testimony as it relates to Canas's failure to warn claim.

As with Williams's testimony, the trial court was authorized to conclude that Shore's testimony on issues other than medical malpractice was admissible under OCGA § 24-9-67.1(b). As for Shore's testimony on the issue of Al-Jabi's and Kaminer's alleged medical malpractice, *see* Division 3(c), *supra*.

(c) John W. Sleasman, M.D., Janice E. Milligan, M.D., and Steven L. Shore, M.D., on the professional standard of care.

John W. Sleasman, M.D., testified as to his opinion that Al-Jabi's and Kaminer's failure to keep a growth chart regarding Canas and to attempt to determine the cause of his profoundly stunted growth fell below the standard of care. Sleasman also criticized the doctors' failure to recognize the significance of Canas's transfusion history coupled with his repeated fever-inducing illnesses, chronic infections, and other classic symptoms of pediatric AIDS. Similarly to Sleasman, Janice E. Milligan, M.D., testified

as to her opinion that Al-Jabi's and Kaminer's failure to monitor Canas's growth and to compare his growth to the curves on a standard growth chart fell below the standard of care. Milligan also criticized Al-Jabi's and Kaminer's focus on Canas's cardiac function and transitory illnesses and their failure to look "at the larger picture" and consider the possible implications of his transfusion history, his growth disturbance, and the frequency and nature of his infectious illnesses. Milligan opined that Al-Jabi and Kaminer should have investigated whether Canas's health problems might have been caused by something other than his congenital heart defect or made appropriate referrals for such investigation. Shore opined that Al-Jabi's and Kaminer's treatment of Canas, particularly their failure to recognize his failure to grow normally, their failure to consult his medical records, and their failure to refer Canas for further examination and treatment, fell below the standard of care. In denying the motions to disqualify Sleasman, Milligan, and Shore, the trial court applied OCGA § 24-9-67.1(c), which governs the admissibility in professional malpractice actions of "the opinions of an expert, who is otherwise qualified as to the acceptable standard of conduct of the professional whose conduct is at issue[.]" *See* Division 3(b), *supra*.

Kaminer and the Board contend that the trial court erred in finding that Sleasman, Milligan, and Shore are qualified under OCGA § 24-9-67.1(c) to testify regarding the standard of care governing Kaminer's professional conduct because the witnesses

are not regularly engaged in the active practice of Kaminer's specialty, pediatric cardiology. In essence, Kaminer and the Board argue that OCGA § 24-9-67.1(c) requires that an expert testifying about the standard of care in a medical malpractice case actively practice in the same specialty or practice area as the professional whose conduct was alleged to be negligent. We recently rejected this argument in *Cotten v. Phillips*. In that case, we held that the General Assembly intended the statute to require simply that "an expert must have knowledge and experience in the area of practice or specialty about which [the expert] is providing testimony." 280 Ga.App. at 284, 633 S.E.2d 655. We held that the statute's language plainly contemplates "that [an] expert may very well have a different area of practice than the defendant doctor." *Id.* at 284-285, 633 S.E.2d 655. Under the statute, it is the expert's qualifications, vis a vis the area of practice or specialty in which the expert is providing the opinion, rather than the defendant doctor's specialty or area of practice, that controls whether the trial court should allow the expert's testimony. *Id.*

This distinction becomes clear in application. The plaintiff in *Cotten v. Phillips* sought to use the testimony of a vascular surgeon on the issue of whether, given the patient's medical history, the defendant doctor, an orthopedic surgeon, negligently failed to assess the vascular issues involved in the patient's surgery and recovery. *Id.* at 281-282, 633 S.E.2d 655. We found that the evidence in the record supported

the trial court's determination that the area of practice in which the opinion was to be given was vascular surgery and that the witness, as a vascular surgeon, was qualified to give an opinion in that area. *Id.* at 287, 633 S.E.2d 655.

In this case, the trial court was authorized to find that Canas's experts are offering opinions in the area of practice or specialty of pediatric medicine. As the trial court noted, for the previous five years, Sleasman has practiced in the fields of pediatrics, allergy and immunology, and diagnostic and laboratory immunology; Milligan has practiced in the area of pediatrics, specializing in primary care; and Shore has practiced in pediatrics, specializing in infectious diseases. Thus, the record supported the trial court's finding that each of these witnesses has been actively engaged in the practice of pediatrics for at least three of the last five years with sufficient frequency to establish an appropriate level of knowledge concerning the practice of pediatric medicine. *Cotten v. Phillips,* 280 Ga.App. at 287, 633 S.E.2d 655. The trial court did not abuse its discretion in denying the motions to disqualify Canas's experts based on OCGA § 24-9-67.1(c).

Having found that the trial court did not abuse its discretion in qualifying Canas's expert witnesses for any of the reasons argued, we affirm the trial court's evidentiary rulings.

Judgment affirmed.

JOHNSON, P.J., and Miller, J., concur.

APPENDIX C

Supreme Court Order dated February 27, 2006

APPENDIX C

[SEAL] SUPREME COURT OF GEORGIA

Atlanta February 27, 2006

The Honorable Supreme Court met pursuant to adjournment.

The following order was passed:

S06A0943. CHARLES CANAS, et al. v. AYMAN AL-JABI, et al.

S06X0944. SHARON J. KAMINER v. CHARLES CANAS, et al.

S06X0945. AYMAN AL-JABI v. CHARLES CANAS, et al.

S06X0946. BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA v. CHARLES CANAS, et al.

S06X0947. MCG HEALTH, INC. v. CHARLES CANAS, et al.

This appeal and cross-appeals arise out of a medical malpractice action brought on behalf of a minor. The trial court granted summary judgment to the defendants for all malpractice claims in which the alleged negligence occurred more than five years before suit was brought. The trial court held that OCGA §§ 9-3-71 and 9-3-73 do not violate the due process or equal protection clauses of the United States or Georgia constitutions, and it is the constitutional rulings that cause the appellants to invoke this Court's jurisdiction. However, this Court has previously upheld these statutes against the same challenges as

they relate to minors. See *Crowe v Humana Hospital,* 263 Ga. 833 (439 SE2d 654) (1994); *Smith v. Cobb County-Kennestone Hosp. Authority,* 262 Ga. 566 (423 SE2d 235) (1992). Accordingly, the constitutional rulings do not invoke this Court's jurisdiction, *Zepp v. Mayor and Council of the City of Athens,* 255 Ga. 449 (339 SE2d 576) (1986). Accordingly, the appeal and cross-appeals are hereby transferred to the Court of Appeals.

SUPREME COURT OF THE STATE OF GEORGIA
Clerk's Office, Atlanta

[SEAL] I hereby certify that the above is a true extract from the minutes of the Supreme Court of Georgia

Witness my signature and the seal of said court hereto affixed the day and year last above written.

/s/ Lynn M. Struckcomb,
Chief Deputy Clerk

APPENDIX D

Superior Court Order filed September 19, 2005

APPENDIX D

IN THE SUPERIOR COURT OF GLYNN COUNTY

STATE OF GEORGIA

CHARLES AMD [sic] LESA CANAS, As Natural Guardians and Next Friends of Derek Canas, a Minor,	)	**CIVIL ACTION File No. 01-01831**
Plaintiffs,	)	
vs.	)	
AYMAN AL-JABI, M.D., SHARON J. KAMINER, M.D., BOARD OF REGENTS OF THE UNIVERSITY OF SYSTEM OF GEORGIA d/b/a MEDICAL COLLEGE OF GEORGIA HOSPITALS AND CLINICS, and MCG HEALTH, INC.	)	
Defendants.	)	

ORDER

(Filed Sept. 19, 2005)

This case comes before the court on Defendants' Motion for Summary Judgment and Motions to Disqualify Witnesses, For the reasons set forth below, this court grants partial summary judgment to the

defendants and denies Defendants' Motions to Disqualify Witnesses.

Summary Judgment is granted to Defendants for all medical malpractice claims in which the negligence that is the basis of the claim occurred more than 5 years before suit was filed. (The 5 year date is December 28, 1996 for all defendants except the Board of Regents; the 5 year date for the Board of Regents is February 7, 1998.) O.C.G.A. § 9-3-71(b) is the Georgia statue of repose in medical malpractice actions; it states: "(b) Notwithstanding subsection (a) of this Code section, in no event may an action for medical malpractice be brought more than five years after the date on which the negligent or wrongful act or omission occurred." O.C.G.A. § 9-3-71(b). It is also clear that Georgia courts interpret this statute strictly.

> "Whether by discovery, which delays the accrual of the action, or by infancy, incompetency, or fraud, which may toll the statute of limitation for up to five years . . . , nothing stops the abrogation of the action by the statute of repose; five years after the negligent or wrongful act or omission occurred, despite any non-discovery or any tolling, the medical malpractice action or potential action ceases to exist by abrogation of law under the statute of repose."
>
> *Simmons v. Sonyika, et. al*, 279 Ga. 378, 380 (2005).

While this statute and its interpretation may be unfair, or even absurd as it applies to cases such as this one, it is the law and we must apply it. Accordingly, Summary Judgment is granted to Defendants on all claims for medical malpractice where the alleged negligent or wrongful act or omission occurred more than 5 years before the date on which this action was brought.

Defendants' Motion for Summary Judgment is denied as to all claims for medical malpractice where the alleged negligent or wrongful act or omission occurred within 5 years of the date this action was brought. O.C.G.A. §§ 9-3-71(a), (b), and (c) make it clear that negligent or wrongful acts or omissions occurring within 5 years of the date an action is brought are actionable if the claims are brought within two years of the occurrence of the injury they caused and, therefore, not barred by the statute of limitations.

> "(a) Except as otherwise provided in this article, an action for medical malpractice shall be brought within two years after the date on which an injury or death arising from a negligent or wrongful act or omission occurred.
>
> (b) Notwithstanding subsection (a) of this Code section, in no event may an action for medical malpractice be brought more than five years after the date on which the negligent or wrongful act or omission occurred.

> (c) Subsection (a) of this Code section is intended to create a two-year statute of limitations. Subsection (b) of this Code section is intended to create a five-year statute of ultimate repose and abrogation. O.C.G.A. § 9-3-71 (2005).

Accordingly, Summary Judgment is Denied to Defendants on all medical malpractice claims where the injury occurred within 2 years of the date this action was filed and the negligent or wrongful act or omission that caused the injury occurred within 5 years of the date this action was filed.

Defendants' Motions to Disqualify John W. Sleasman, M.D., Janice E. Milligan, M.D., and Steven L. Shore, M.D. as expert witnesses is denied. Plaintiff's experts meet the requirements of O.C.G.A. § 24-9-67.1. Since defendants question whether they are qualified to testify in this area of medicine, the applicable portion of O.C.G.A. § 24-9-67.1 is § (c)(2)(a):

> "(2) In the case of a medical malpractice action, had actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given as the result of having been regularly engaged in:
>
> (a) The active practice of such area of specialty of his or her profession for at least three of the last five years, with sufficient frequency to establish an appropriate level of knowledge, as determined by the judge, in performing the procedure, diagnosing the

> condition, or rendering the treatment which is alleged to have been performed or rendered negligently by the defendant whose conduct is at issue;"

Each of these experts is proposed to testify in the area of pediatrics. Each of them has been actively engaged in the practice of pediatrics for at least three of the last five years with sufficient frequency to establish an appropriate level of knowledge concerning the practice of pediatric medicine.[1]

Defendants read the statute to state that each expert must practice in exactly the same specialty as the defendant. Defendants' reading of the statute is adverse to the plain reading of the statute. The statute states the expert must have "actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given" O.C.G.A. § 9-24-67.1(c)(2). The statute does not state that the expert must have actual professional knowledge and experience in the exact area of practice or specialty in which the defendant doctor specializes. It is apparent that the legislature realizes that doctors' areas of practice often overlap. This overlap is apparent

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[1] Expert Sleasman practices in the fields of Pediatrics, Allergy and Immunology, and Diagnostic and laboratory Immunology and has practiced in each of these areas for the last 5 years; Expert Shore practices Pediatrics specializes in pediatric infectious diseases and has practiced in these areas for the last 5 years; Expert Milligan practices Pediatrics and specializes in primary care and has practiced in these areas for the last 5 years.

from the practice of medicine as doctors from several different specialties often participate in the treatment of a patient. This Court's reading of the statute is also supported by other courts facing the same question, *See Murphy, et al. v. Anders, et al.,* Superior Court of Muscogee County, Civil Action Number SU01CV3120, Order dated August 5, 2005 (stating that a hematologist is qualified to testify concerning sickle cell anemia when the defendant doctor is an emergency room doctor); *Phillips v. Cotten,* State Court of Dougherty County, Civil Action Number 01-SCV815, Order dated June 10, 2005 (stating that a vascular surgeon is qualified to testify concerning vascular issues when the defendant doctor is a general orthopedic surgeon).

Considering the wording of the statute and the rulings of other similarly situated courts, this Court therefore rules that experts must only have actual professional knowledge and experience in the subject matter to which they are testifying, not that an expert's entire practice be in the same exact specialty as that of the defendant.

Accordingly, Defendants' Motions to disqualify witnesses Sleasman, Shore and Milligan is Denied.

Defendants' Motions to Disqualify Dr. Williams as an expert witness is denied. Although Dr. Williams meets the requirements of O.C.G.A. 24-9-67.1(c)(2)(a) as outlined above, this is not necessary as he is not testifying to allegations of medical malpractice. Defendants' argument that Dr. Williams' testimony does not meet *Daubers* standards as now codified in

Georgia law is without merit. O.C.G.A. 24-9-97.1(b) states:

> "(b) If scientific, technical, or other specialized knowledge will assist the trier of fact in any cause of action to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise, if:
>
> (1) The testimony is based upon sufficient facts or data which are or will be admitted into evidence at the hearing or trial;
>
> (2) The testimony is the product of reliable principles and methods; and
>
> (3) The witness has applied the principles and methods reliably to the facts of the case."

Dr. Williams vast experience, knowledge, skill, training, and education qualify him to testify concerning medical records. *See* Exhibit 2 of Williams Deposition, C.V. of Dr. Roger A. Williams. Dr. Williams' testimony will be based on facts or data which will be admitted into evidence at trial. Dr. Williams testimony is the product of reliable principles and methods.[2] Dr.

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[2] Dr. Williams expresses that his actions were based on recommendations by the CDC and Public Health Service in 1987 and that they were reinforced by the "Report of the Presidential Commission on Human Immunodeficiency Virus Epidemic"

(Continued on following page)

Williams has applied these principles and methods reliably to the facts of this case. *See* Affidavit of Roger A. Williams, M.D. Dr. Williams' principles and methods were applied in the late 1980s and early 1990s and were successful. In fact, the standard of care used by Dr. Williams has proven to be the best and most effective standard of care in dealing with patients who may have received AIDS through a blood transfusion. Had it been applied in the case at bar, it is likely that no litigation would have occurred and Derek Canas' injuries would have been greatly lessened. Dr. Williams' principles and methods are clearly reliable and should be admitted.

In oral argument, defendants argued that since Dr. Williams proposed a high standard of care that few hospitals attained, his testimony was not acceptable. This Court disagrees with that proposition. When evaluating admissibility of evidence, courts must consistently apply the law in all cases. If the court rules that a plaintiff's expert cannot testify because her standard of care or scientific reliability has proven to be too high because she was one of the few in the country using that standard or method, the court must also rule that defendant's expert in the same situation could not testify because his standard of care or method would be too high if he was one of the few in the country using that higher standard.

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published June 24, 1998. (Item number 10 in the affidavit of Dr. Williams)

This would create the awkward situation where a defendant could not present evidence from the leading practitioner in his field that had a very high standard of care or very advanced method for performing a procedure yet another expert could testify for the plaintiff to a lower standard of care or less advanced method of performing a procedure.[3] Judges are not called on to base decisions regarding admissibility on whether the plaintiff or defendant proposes the evidence. Instead, judges must determine whether testimony meets scientific standards for reliability and is based upon application of those scientific standards to the facts of the case. Dr. Williams testimony clearly meets these standards. Therefore, Defendants' Motion to Disqualify Dr. Williams as an expert is Denied.

Accordingly, Defendants' Motions for Summary Judgment are Granted as to all claims of medical malpractice occurring more than 5 years before this suit was filed and Denied for all claims of medical malpractice occurring within 5 years of the day this

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[3] Effectively, defense counsel's argument would make it so that a world renowned surgeon who had perfected a technique that, for example, would effectively allow someone to recover from an ACL injury in two months could not testify that a surgeon followed his exact method for treating the injury but that a less advanced doctor who had no idea how to perform this advanced operation could testify against the surgeon using the advanced method because "most doctors did not use the advanced method so it is not in the mainstream of science." It is extremely doubtful that the legislature intended a result such as this that would discourage doctors from using advanced treatments and having a higher standard of care.

suit was filed; Defendants' Motions to Disqualify Expert Witnesses Sleasman, Shore, Milligan, and Williams are Denied.

This 19 day of September 2005.

/s/ Amanda F. Williams
AMANDA F. WILLIAMS
Judge, Superior Courts
Brunswick Judicial Circuit

APPENDIX E

Superior Court Order filed October 17, 2005

APPENDIX E

**IN THE SUPERIOR COURT
OF GLYNN COUNTY
STATE OF GEORGIA**

CHARLES AND LESA CANAS, As Natural Guardians and Next Friends of DEREK CANAS, a minor,	
Plaintiffs,	
vs.	
AYMAN AL-JABI, M.D., SHARON J. KAMINER, M.D., BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA d/b/a MEDICAL COLLEGE OF GEORGIA HOSPITALS AND CLINICS, and MCG HEALTH, INC.	**CIVIL ACTION FILE NO. 01-01831**
Defendants.	

ORDER

(Filed Oct. 17, 2005)

This Court having entered an Order on September 19, 2005 dispositive of certain issues pertaining to summary judgment motions of the parties, and the Order by implication having affirmed the constitutionality of O.C.G.A. §§ 9-3-71 and 9-3-73, the Court

hereby expressly finds that those two statutes do not violate the equal protection or due process clauses of the United States or Georgia Constitutions. See, *Smith v. Cobb County-Kennestone Hospital Authority,* 262 Ga. 566, 423 S.E.2d235 (1992).

This issue has been raised by the plaintiffs in opposition to defense motions for summary judgment. It is of critical importance to the disposition of the case that there be an immediate review of this Order and in the event that an appellate court determines that this Order or the prior Order of the Court of September 19, 2005 is not subject to direct appeal, the Court hereby certifies a review of this Order for immediate review.

This 14 day of October, 2005.

/s/ Amanda F. Williams
AMANDA F. WILLIAMS
Judge, Glynn County
Superior Court
Brunswick Judicial Circuit

APPENDIX F

Supreme Court Order denying Motion for Reconsideration dated April 13, 2006

APPENDIX F

SUPREME COURT OF GEORGIA Atlanta, April 13, 2006

Case No. S06X0947

The Honorable Supreme Court met pursuant to adjournment.

The following order was passed:

MCG HEALTH, INC. v. CHARLES CANAS et al.

Upon consideration of the Motion for Reconsideration filed in this case, it is ordered that it be hereby denied.

SUPREME COURT OF THE STATE OF GEORGIA

Clerk's Office, Atlanta

I hereby certify that the above is a true extract from the minutes of the Supreme Court of Georgia

Witness my signature and the seal of said court hereto affixed the day and year last above written.

/s/ Sherie M. Welch, Clerk

APPENDIX G

Supreme Court Order denying Motion for Reconsideration filed December 14, 2007

APPENDIX G

SUPREME COURT OF GEORGIA Atlanta, December 14, 2007

Case No. S07G0489

The Honorable Supreme Court met pursuant to adjournment.

The following order was passed:

SHARON J. KAMINER v. CHARLES CANAS et al.

Upon consideration of the Motion for Reconsideration filed in this case, it is ordered that it be hereby denied.

All the Justices concur, except Sears, C. J., Hunstein, P. J., and Thompson, J., who dissent.

SUPREME COURT OF THE STATE OF GEORGIA

Clerk's Office, Atlanta

[Feb. 7, 2008]

[SEAL] I hereby certify that the above is a true extract from the minutes of the Supreme Court of Georgia

Witness my signature and the seal of said court hereto affixed the day and year last above written.

/s/ Jeanette Eidson, *Dep. Clerk*

APPENDIX H

Statutes

APPENDIX H

O.C.G.A. § 1-2-8. Rights of minors.

The law prescribes certain ages at which persons shall be considered of sufficient maturity to discharge certain civil functions, to make contracts, and to dispose of property. Prior to those ages they are minors and are, on account of that disability, unable to exercise these rights as citizens.

O.C.G.A. § 9-2-28. Effect of action by minor alone.

An action commenced and prosecuted by an infant alone shall not be void. Although the action may be defective in wanting a guardian or next friend, the defect shall be amended before verdict and cured by verdict.

O.C.G.A. § 9-3-33. Injuries to the person

Actions for injuries to the person shall be brought within two years after the right of action accrues, except for injuries to the reputation, which shall be brought within one year after the right of action accrues, and except for actions for injuries to the person involving loss of consortium, which shall be brought within four years after the right of action accrues.

O.C.G.A. § 9-3-71. General limitations[1]

Except as otherwise provided in this article, an action for medical malpractice shall be brought within two years after the date on which the negligent or wrongful act or omission occurred. [Invalid 1976 version of statute.]

O.C.G.A. § 9-3-71. General limitations

(a) Except as otherwise provided in this article, an action for medical malpractice shall be brought within two years after the date on which an injury or death arising from a negligent or wrongful act or omission occurred.

(b) Notwithstanding subsection (a) of this Code section, in no event may an action for medical malpractice be brought more than five years after the date on which the negligent or wrongful act or omission occurred.

(c) Subsection (a) of this Code section is intended to create a two-year statute of limitations. Subsection (b) of this Code section is intended to create a five-year statute of ultimate repose and abrogation.

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[1] This former version of O.C.G.A. § 9-3-71 was enacted in 1976, and was held unconstitutional in *Shessel v. Stroup*, 316 S.E.2d 155 (Ga. 1984) after being held unconstitutional in its application to a wrongful death case where the death occurred more than two years after the negligent act in *Clark v. Singer*, 298 S.E.2d 484 (1983).

(d) Nothing contained in subsection (a) or (b) of this Code section shall be construed to repeal Code Section 9-3-73, which shall be deemed to apply either to the applicable statutes of limitation or repose. [1985 statute currently in effect.]

O.C.G.A. § 9-3-72. Foreign objects left in body

The limitations of Code Section 9-3-71 shall not apply where a foreign object has been left in a patient's body, but in such a case an action shall be brought within one year after the negligent or wrongful act of omission is discovered. For the purpose of this Code section, the term "foreign object" shall not include a chemical compound, fixation device, or prosthetic aid or device.

O.C.G.A. § 9-3-73. Certain disabilities and exceptions applicable.

(a) Except as provided in this Code section, the disabilities and exceptions prescribed in Article 5 of this chapter[2] in limiting actions on contracts shall be allowed and held applicable to actions, whether in tort or contract, for medical malpractice.

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[2] The chapter includes O.C.G.A. § 9-3-90, which recognizes that minors are otherwise legally incompetent and under a disability until the age of majority. Hence, their claims are tolled until the age of majority.

(b) Notwithstanding Article 5 of this chapter, all persons who are legally incompetent because of mental retardation or mental illness and all minors who have attained the age of five years shall be subject to the periods of limitation for actions for medical malpractice provided in this article. A minor who has not attained the age of five years shall have two years from the date of such minor's fifth birthday within which to bring a medical malpractice action if the cause of action arose before such minor attained the age of five years.

(c) Notwithstanding subsections (a) and (b) of this Code section, in no event may an action for medical malpractice be brought by or on behalf of:

(1) A person who is legally incompetent because of mental retardation or mental illness more than five years after the date on which the negligent or wrongful act or omission occurred; or

(2) A minor: (A) After the tenth birthday of the minor if such minor was under the age of five years on the date on which the negligent or wrongful act or omission occurred; or (B) After five years from the date on which the negligent or wrongful act or omission occurred if such minor was age five or older on the date of such act or omission.

(d) Subsection (b) of this Code section is intended to create a statute of limitations and subsection (c) of this Code section is intended to create a statute of repose.

(e) The limitations of subsections (b) and (c) of this Code section shall not apply where a foreign object has been left in a patient's body. Such cases shall be governed by Code Section 9-3-72.[3]

(f) The findings of the General Assembly under this Code section include, without limitation, that a reasonable relationship exists between the provisions, goals, and classifications of this Code section and the rational, legitimate state objectives of providing quality health care, assuring the availability of physicians, preventing the curtailment of medical services, stabilizing insurance and medical costs, preventing stale medical malpractice claims, and providing for the public safety, health, and welfare as a whole.

(g) No action which, prior to July 1, 1987, has been barred by provisions relating to limitations of actions shall be revived by this article, as amended. No action which would be barred before July 1, 1987, by the provisions of this article, as amended, but which would not be so barred by the provisions of this

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[3] O.C.G.A. § 9-3-72 provides that "the limitations of Code § 9-3-71 shall not apply where a foreign object has been left in a patient's body, but in such a cause an action shall be brought within one year after the negligent or wrongful act or omission is discovered . . . " This statute is challenged by implication as well because it arbitrarily allows a discovery rule for surgical patients but no others, and couples with Georgia appellate cases applying a discovery rule in an ill-defined group of cases arising under § 9-3-71.

article and Article 5 of this chapter in force immediately prior to July 1, 1987, shall be barred until July 1, 1989

O.C.G.A. § 9-3-90. Persons under disability or imprisoned when cause of action accrues.

(a) Minors and persons who are legally incompetent because of mental retardation or mental illness, who are such when the cause of action accrues, shall be entitled to the same time after their disability is removed to bring an action as is prescribed for other persons.

O.C.G.A. § 9-11-9.1. Affidavit of expert to be filed with complaint in action for damages alleging professional malpractice

(a) In any action for damages alleging professional malpractice against a professional licensed by the State of Georgia and listed in subsection (d) of this Code section or against any licensed health care facility alleged to be liable based upon the action or inaction of a health care professional licensed by the State of Georgia and listed in subsection (d) of this Code section, the plaintiff shall be required to file with the complaint an affidavit of an expert competent to testify, which affidavit shall set forth specifically at least one negligent act or omission claimed to exist and the factual basis for each such claim.

(b) If a plaintiff files an affidavit which is allegedly defective, and the defendant to whom it

pertains alleges, with specificity, by motion to dismiss filed on or before the close of discovery, that said affidavit is defective, the plaintiffs complaint is subject to dismissal for failure to state a claim, except that the plaintiff may cure the alleged defect by amendment pursuant to Code Section 9-11-15 within 30 days of service of the motion alleging that the affidavit is defective. The trial court may, in the exercise of its discretion, extend the time for filing said amendment or response to the motion, or both, as it shall determine justice requires.

(c) If a plaintiff fails to file an affidavit as required by this Code section and the defendant raises the failure to file such an affidavit by motion to dismiss filed contemporaneously with its initial responsive pleading, such complaint shall not be subject to the renewal provisions of Code Section 9-2-61 after the expiration of the applicable period of limitation, unless a court determines that the plaintiff had the requisite affidavit within the time required by this Code section and the failure to file the affidavit was the result of a mistake.

(d) The professionals to which this Code section applies are:

(10) Medical doctors;

O.C.G.A. § 9-11-17(c). Parties plaintiff and defendant; capacity.

Infants or incompetent persons. Whenever an infant or incompetent person has a representative, such as a general guardian, committee, conservator, or other like fiduciary, the representative may bring or defend an action on behalf of the infant or incompetent person. If an infant or incompetent person does not have a duly appointed representative, he may bring an action by his next friend or by a guardian ad litem. The court shall appoint a guardian ad litem for an infant or incompetent person not otherwise represented in an action or shall make such other order as it deems proper for the protection of the infant or incompetent person. No next friend shall be permitted to receive the proceeds of any personal action, in the name and on behalf of an infant, or incompetent person, until such next friend shall have entered into a sufficient bond to the Governor, for the use of the infant and the infant's representatives, conditioned well and fully to account for and concerning such trust, which bond may be sued on by order of the court in the name of the Governor and for the use of the infant. Such bond shall be approved by the court in which the action is commenced and such approval shall be filed in such clerk's office.

O.C.G.A. § 39-1-1. Age of majority; nonresident students

(a) The age of legal majority in this state is 18 years; until that age all persons are minors.